DOCUMENT RESUME

ED 452 995	PS 029 504

TITLE	Head Start, Medicaid, and CHIP: Partners for Healthy Children. A Guide for Head Start Programs.
INSTITUTION	National Head Start Training and Technical Assistance Resource Center, Arlington, VA.
SPONS AGENCY	Administration for Children, Youth, and Families (DHHS), Washington, DC. Head Start Bureau.
PUB DATE	1999-09-00
NOTE	132p.
CONTRACT	105-96-2010
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	*Agency Cooperation; *Child Health; *Cooperative Planning; Enrollment; *Health Insurance; *Preschool Children; Preschool Education; Program Descriptions
IDENTIFIERS	Childrens Health Insurance Program; Early Periodic Screening Diagnosis and Treatment; Medicaid; Project Head Start

ABSTRACT

Eleven federal agencies have established a multi-agency effort to increase enrollment of uninsured children in Medicaid and the state Child Health Insurance Program (CHIP). Noting that the cooperative efforts of agencies with jurisdiction over children's programs within the Department of Health and Human Services offer new opportunities for Head Start programs to work with Medicaid and CHIP agencies to increase enrollment for both Head Start children and their siblings, this book provides guidance for Head Start programs to collaborate effectively with other agencies. Chapter 1, "Working with Partners," discusses planning successful collaboration and making state and local partnerships work. Chapter 2, "Reaching out to Families," includes informing Head Start families about Medicaid and CHIP, identifying typical barriers to service, and serving the needs of the Head Start population. Chapter 3, "Partnerships in Action: Strategies that Work," presents effective outreach strategies suggested by the Health Care Financing Administration for reaching eligible children. Six appendices describe Head Start and Early Head Start services, detail the performance standards for health services, describe the child health component of the Medicaid program and the state Children's Health Insurance Program, contain the federal intra-agency agreement, delineate available services by state, and identify state contacts for CHIP, Medicaid, and Head Start collaboration offices, as well as regional and national agency contacts. (KB)

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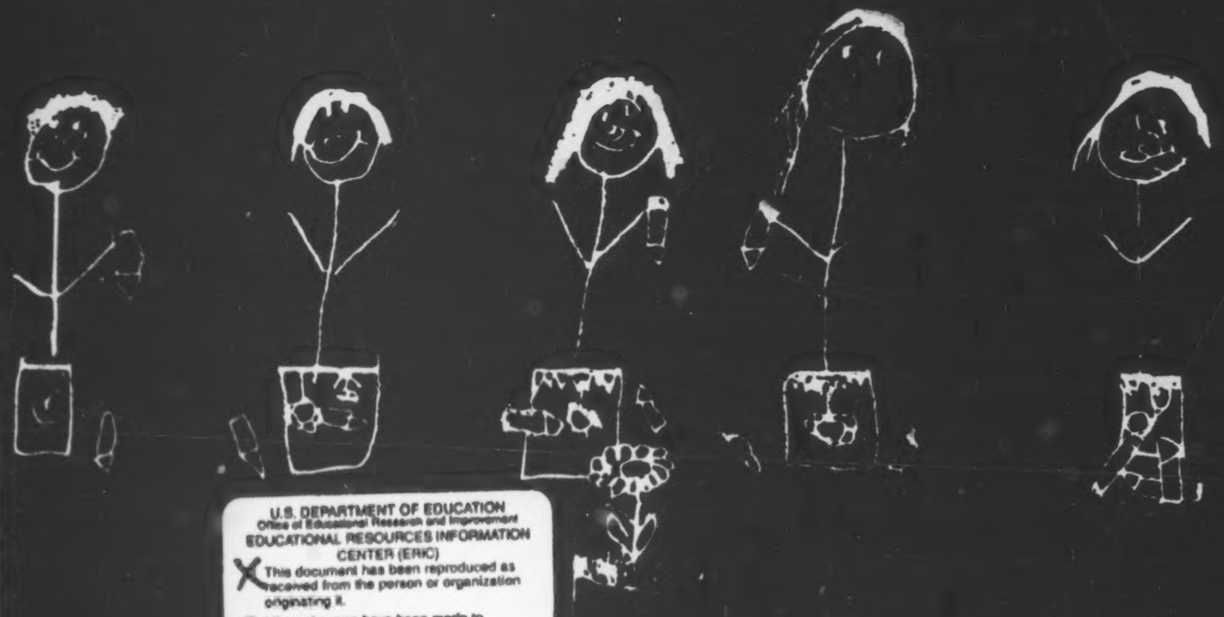
Partners for Healthy Children



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Purpose of The Guide

The Guide will:

- Provide a foundation for greater partnership, collaboration, and understanding among local Head Start programs and the health care community to improve the health status of low-income children in this country;
- Acquaint Head Start programs with the benefits of Medicaid and CHIP enrollment and the role of Managed Care Organizations (MCOs);
- Inform Medicaid and CHIP program staff and MCOs about the pivotal role Head Start plays in promoting the healthy development of low-income children and about opportunities to work with Head Start to achieve Medicaid and CHIP goals;
- Discuss how Head Start can develop and/or expand Medicaid and CHIP outreach activities;
- Provide examples of linkages that demonstrate the benefits of collaborative efforts; and
- Direct Head Start programs, Title V, Medicaid and CHIP staff and directors, and state EPSDT coordinators to additional sources of information, including strategies for developing and maintaining successful program linkages and practices.

This document was prepared under Contract No. 105-96-2010 of the Head Start Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, by the National Head Start Training and Technical Assistance Resource Center, PaL-Tech., Inc., 1901 N. Fort Myer Drive, Suite 301, Arlington, VA 22209.

The cover art, "Partners Working Together," is by Jim Likin.

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Head Start, Medicaid, and CHIP

Partners for Healthy Children

A Guide for Head Start Programs

The Administration for
Children and Families

September 1999

Health Care Financing
Administration

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Introduction

Head Start's goal for the year 2002 is to provide Head Start services to 1 million children. Most of these children will be eligible for the Medicaid program or the State Children's Health Insurance Program (CHIP). The Administration for Children and Families (ACF) and the Health Care Financing Administration (HCFA) are cooperating to bridge the gap between Head Start and these important programs. Their shared vision is to support the healthy development and well being of children.

Implementing this vision will link children and families to comprehensive health services and support children's learning and developmental potential. Children who receive preventive and other necessary health services, such as mental and dental health services, are better prepared to learn and to succeed in school. The effect of this valuable work, which brings health insurance and services to low-income families, will be a rising rate of immunizations, prompt screenings, early detection of health problems, broader use of prevention services, and medical homes for Head Start children. Neglecting this work would endanger the health of children, risk their readiness for school, and jeopardize their preparation for a strong and healthy adulthood.

Federal Partnerships to Maximize Resources

To implement their shared vision and common goals, HCFA and ACF have established and expanded partnerships to ensure that children gain access to the important health services and other key federal programs to which they are entitled, such as Title V Maternal and Child Health Services Block Grants. Medicaid, CHIP, and Head Start partnerships offer exciting benefits, including a unique opportunity to provide families with a coordinated approach to receiving services. The advantages of these partnerships include:

- Early detection of illnesses, potential disabilities, and diseases;
- An avenue to help families identify and gain access to quality health care services, including preventive health services and immunizations and services to address acute or chronic illnesses;
- Reduced duplication of efforts by combining the application process for Head Start with a preliminary Medicaid or other state CHIP health insurance program application;
- An opportunity to identify uninsured children and streamline enrollment in the Medicaid program, CHIP, other state-sponsored health insurance programs, and the Supplemental Nutrition Program for Women, Infants and Children (WIC);

- The link to a network of health and developmental services to improve the quality and efficiency of delivering health services for children; and
- The combination of all these advantages to offer children and their families a coordinated approach to receiving needed services.

Federal Programs to Ensure the Health of Children

There are more opportunities today to insure the health of low-income children. HCFA and ACF are working cooperatively to promote opportunities for Medicaid, CHIP, and Head Start partnerships to expand access to this insurance at the federal, state, and local levels. Title V Maternal and Child Health Services Block Grants also advance partnerships to benefit child health.

Head Start and Early Head Start

The Head Start Bureau of ACF administers Head Start and Early Head Start programs, which provide funds to local community agencies, school boards, universities, migrant programs, and tribes to assist in providing comprehensive child development services to children in low-income families. In Fiscal Year 1998, over 822,000 children were enrolled in 48,000 Head Start classrooms. Six hundred Early Head Start projects are now serving 35,000 children under the age of three.

Head Start programs enlist community support to ensure that each child and the child's family are connected to an ongoing source of continuous, accessible health care. Appendix 1 describes Head Start and its health services.

Medicaid

HCFA's Medicaid program finances health services for certain individuals and families with low incomes and few resources. Medicaid, a jointly funded federal-state partnership, is administered by the states, commonwealths, and territories within broad federal guidelines and provides health care coverage for more than 20 million children. States have the flexibility to design their own Medicaid programs, but each state is required to provide a package of comprehensive and preventive child health services to Medicaid-eligible individuals under age 21. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) is the name used to describe this package of health services provided under Medicaid. It is important to keep in mind that some states may call these services something other than EPSDT, e.g., Doctor Dynasaur in Vermont. See Appendix 2 for further discussion of Medicaid.

The State Children's Health Insurance Program (CHIP)

The Balanced Budget Act of 1997 created Title XXI of the Social Security Act, the State Children's Health Insurance Program. Like Medicaid, CHIP is funded through a federal-state partnership, administered by the states under broad federal guidelines. CHIP is the largest single expansion of health insurance coverage for children in more than 30 years. This new initiative set aside $24 billion in federal dollars over five years for states to provide new health coverage for low-income children who are not eligible for Medicaid. States may call their CHIP programs by another title, e.g., Sooner Care in Oklahoma. See Appendix 2 for specific information about CHIP.

Title V Maternal and Child Health Services Block Grant

The Maternal and Child Health Bureau, which administers Title V, is a component of the Health Resources and Services Administration (HRSA), an agency of the Public Health Service (PHS) within the Department of Health and Human Services (DHHS).

Title V has operated as a federal-state partnership for more than 60 years. It is a population-based public health program with expertise in the needs of children, adolescents, and pregnant women. It emphasizes program development to prevent adverse health or developmental outcomes, particularly for those with limited access to care or those with special needs. The Title V grants to state health agencies enable states to coordinate and integrate services to families. Grants are used to meet locally determined needs, including preventing death, disease, and disability; assuring access to quality health care; and providing family-centered, community-based services for children with special health care needs. Title V services are "wrap-around" and offer access to care in underserved areas for uninsured, underinsured, and publicly insured families. They include family support services, such as home visiting, and respite care for families caring for children with special health care needs.

Title V funds set aside at the federal level are also used to improve and support community and state service systems through training, research, special projects of regional and national significance (SPRANS), and community-integrated service systems projects (CISS).

Federal Partnerships to Share Outreach

Eleven federal agencies[1] have established a multi-agency effort to increase enrollment of uninsured children in Medicaid and CHIP. The cooperative efforts of agencies with jurisdiction over children's programs within DHHS, including ACF, HCFA, and HRSA, offer new opportunities for Head Start programs to work with Medicaid and CHIP agencies to increase enrollment in health insurance programs for both Head Start children and their siblings.

There are significant and unprecedented new contributions to outreach efforts from the private and public sector to help ensure that all children who are eligible for health insurance benefits receive them. These contributions and a description of specific outreach strategies that can be conducted by Head Start programs are discussed in Chapters 2 and 3.

The need for effective outreach is supported by an analysis of recent Medical Expenditure Panel Survey data.[2] The data showed that 4.7 million children age 18 and under are uninsured, despite the fact that they are eligible for Medicaid. There are many reasons, some of which are complex, for the large number of Medicaid-eligible children not enrolled in the program. For example, many families lack information about Medicaid eligibility. This obstacle can be readily addressed through more effective outreach to enroll children in Medicaid and CHIP. [3]

The appendices at the end of the Guide provide information and resources to foster productive links between Head Start, Medicaid, and CHIP.

Chapter 1

Working with Partners

Chapter Highlights

Levels of partnership

- *Choosing the best level*

How to plan successful collaborations

- *Setting goals and ground rules, overcoming barriers, and meeting the challenges*

Making state and local partnerships work

- *Identifying partners and explaining the benefits of collaborating*
- *Learning from Head Start-State Collaboration Offices*
- *Playing a role in the state planing process*
- *Addressing special concerns and sharing information*

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Head Start has a long history of encouraging programs to initiate a variety of partnerships to involve others in a shared vision and common goal — improving the healthy development and well being of children. Program staffs recognize that they cannot achieve this goal alone and have formed partnerships to meet two important objectives: expanding the scope of their services to families and improving the quality of their services. The partnerships, often formed at the local level, are dynamic and benefit from shared resources. They also offer many opportunities, including joint policy discussions and the chance to design innovative methods to streamline and improve service delivery.

The Head Start Program Performance Standards recognize that Head Start's ability to build comprehensive health services for children depends on the assistance of others with the capacity to extend and expand these services. (See Appendix 1.) Local partnerships among Head Start staff, parents, and community health partners extend Head Start's limited resources. These partnerships also ensure that:

- Parents and partners recognize that health should receive high priority; and
- Children have access to preventive care and treatment by health care professionals.

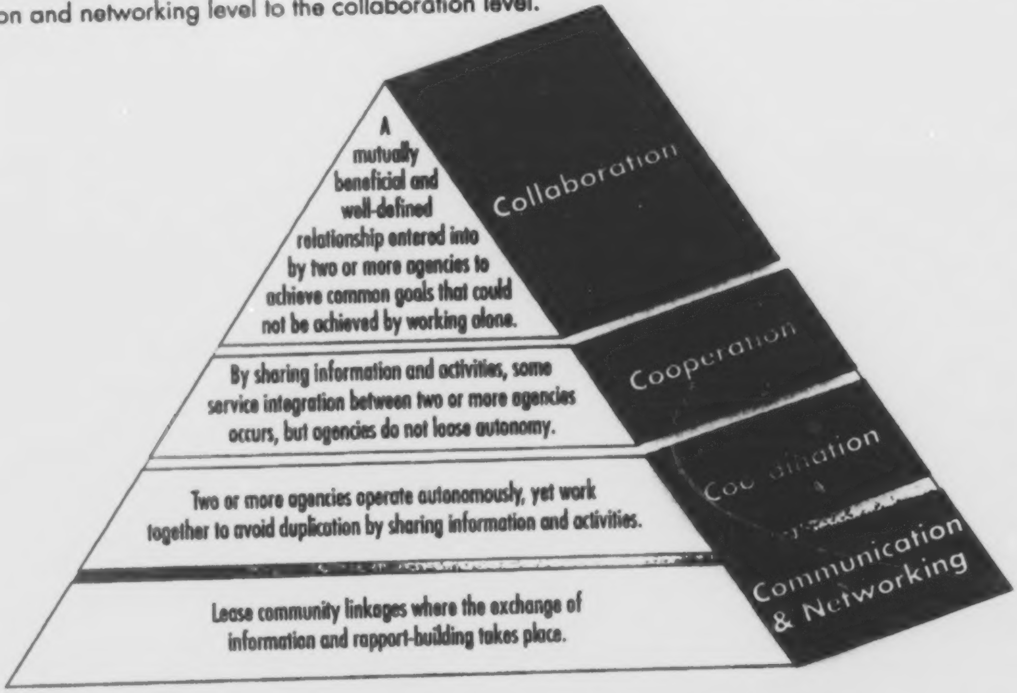
At the national level, recognizing the need for joint efforts to link families to a network of health services, ACF and HCFA signed an Intra-agency Agreement in 1995. (See Appendix 3.) The primary goal of this agreement is to improve outreach and access to quality medical care and preventive services. State and local offices often develop formal agreements to foster links to health services; many also combine efforts to improve services using informal agreements. These formal and informal efforts are successful if they achieve the most important result: better access to expanded and quality health services.

Levels of Partnership

The chart on the opposite page illustrates the levels of community partnership, beginning with the exchange of information, continuing through informal coordination and cooperation, and culminating with formal collaboration. Head Start programs should assess where they are currently and how and when to move to another level to achieve partnership goals. Important first steps are to decide what level of partnership is possible, whether it can be achieved in the community setting, and if partners are receptive.

This illustration demonstrates that, in many areas, collaborations evolve as organizations become more comfortable with one another and more willing to share

Overview: The illustration below shows the increasing intensity of community partnerships as they move from the communication and networking level to the collaboration level.


A mutually beneficial and well-defined relationship entered into by two or more agencies to achieve common goals that could not be achieved by working alone.
Collaboration
By sharing information and activities, some service integration between two or more agencies occurs, but agencies do not loose autonomy.
Cooperation
Two or more agencies operate autonomously, yet work together to avoid duplication by sharing information and activities.
Coordination
Loose community linkages where the exchange of information and rapport-building takes place.
Communication & Networking

risks, responsibilities, and rewards. Collaborating organizations hope for some mutual benefit and try to reach a common purpose. The shared purpose may involve offering services, altering a system, or a combination of service and system goals. There is no "one best model," since both local and state collaborations develop in response to their unique settings.[5] Head Start programs engage in activities at every level displayed on the pyramid.

Planning Successful Collaborative Efforts

Partners working to build a comprehensive health services system for children are motivated by many things, including a common goal. To be successful they must have the capacity to make commitments to meet that goal and must decide:

- When and how best to collaborate;
- How to share planning and leadership;
- How to design a fiscal strategy; and
- How best to negotiate differences to overcome barriers to collaboration.

Examples of Communication and Networking

- Representatives from Medicaid, managed care organizations, and the local health department are active members of the Head Start Health Services Advisory Committee.
- Head Start health staff join with WIC, state health department representatives, representatives from the pediatric dental community, state Title V MCH staff, and Medicaid representatives to assess the oral health status of state children.
- Head Start health specialists join WIC, a local hospital pediatric center, and area Medicaid offices on the community health advisory board dealing with issues like immunizations, lead poisoning, and playground safety. The group also can informally exchange ideas about other health issues affecting children and solve problems.

Examples of Coordination

- Head Start plans a health fair and invites the health department, WIC, and Medicaid to participate.
- Head Start and WIC conduct joint nutrition education sessions for parents enrolled in both programs.
- Head Start works with the local health department to promote, foster, and staff an immunization clinic for children.
- Head Start family service workers provide and conduct outreach services promoting state CHIP enrollment.
- Head Start invites WIC, Medicaid, community schools, and the health department to plan an orientation for families to ensure that all groups make the necessary materials available and scheduled Head Start events do not conflict with other groups' activities.

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Examples of Cooperation

- Families applying for both Head Start and Medicaid services use a joint application.
- Head Start centers collect applications for Medicaid and CHIP and offer training about the availability of health insurance.
- A Medicaid/CHIP eligibility worker is outstationed at a local Head Start program.
- Specialized services (OT/PT) for children with disabilities are provided within a Head Start setting. Required activities are incorporated into service plans supported by the staff and are reinforced daily with children and families.

Examples of Collaboration

- The Head Start and Medicaid agency have an interagency agreement.
- The local health department, Head Start, and the local university apply for a Title V grant to develop parent health education materials.
- Local Head Start staff work with other community representatives from WIC, Medicaid, the dental community, the state pediatric society, health departments, and state Title V MCH programs to develop a legislative proposal to increase funding for children's oral health services. When the state legislature approves funding for pilot projects, Head Start programs apply for and receive demonstration grants to try new approaches to improving oral health services.
- Head Start and WIC operate from the same offices and provide integrated services to families to reduce costs, increase service hours, and share educational opportunities.

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The Questions

- Do the partners have a shared understanding of the goal?
- Will the benefits of the partnership outweigh the costs?
- Is there a history of communication and cooperation and a foundation of trust among the community groups and organizations the collaboration will involve? If not, can partners build this history?
- Is each potential partner stable enough to withstand the change that integrating services would introduce?
- Do all of the key players have enough financial and staff leeway to commit some of their resources to collaborative activities?
- Are partners willing to explore ways for key players, such as grassroots organizations operating on shoestring budgets, to participate?

Once a decision has been reached to proceed, the collaborative partners need to set ground rules by deciding:

- Where, when, and how often will partners meet?
- How will the partners share responsibility for organizing and leading the meetings?
- Who will prepare and contribute to the agenda?
- What rules should guide the dialogue?
- Should the partners make decisions by majority rule or consensus?
- What happens if there is a problem or conflict?
- How will the partners handle logistical arrangements?
- Under what circumstances should there be a third-party facilitator?

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Finally, people who are trying to collaborate must meet challenges by:

- Defining a shared vision;
- Including a representative of all interested and affected persons in discussions as early as possible;
- Building trust;
- Aligning goals and standards;
- Ensuring cross-agency training and support for staff; and
- Dealing with policy issues, multiple funding streams, eligibility requirements, and differences in regulations.[7]

These decisions are challenging. To ensure sound collaborations, organizers can pose questions and decide ground rules. The answers to the questions will help to determine whether a particular collaboration should be pursued. Ground rules will prepare them to proceed.[6]

A successful collaboration will include evidence that these challenges have been met. The collaboration will also define attainable goals and include a distinct and structured membership with skilled leadership. Ongoing communication, open dialogue and shared resources will help to ensure that the collaboration will continue and problems will be aired and solved.[8]

Collaboration Resources

To support their efforts, Head Start program staff members may wish to explore resources including:

1. *Community Partnerships: Working Together,* a Training Guide for the Head Start Learning Community, March 31, 1998. This technical guide expands the capacity of staff to develop collaborative partnerships. The activities provide strategies for programs, staff, and families to work together within the community on behalf of families, and build supportive peer relationships.

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Web site: http://www.hskids-tmsc.org/publications/publicat.htm

2. *Together We Can,* a national leadership development and capacity-building initiative to strengthen children, youth, and communities. Partners include the *Institute for Educational Leadership, California Tomorrow,* the *Child and Family Policy Center*, and the *Program for Community Problem Solving*. The non-profit initiative provides leadership development and training support, and offers seminars and resource materials, a comprehensive list of resource organizations to support community collaboration, a bibliography, technical assistance networks, a collaborative database, and publications.

For more information contact:

Together We Can Initiative
c/o The Institute for Educational Leadership
1001 Connecticut Ave., NW, Suite 310
Washington, D.C. 20036
Phone: 202-822-8405
Fax: 202-872-4050
Web site: http://www.togetherwecan.org
E-Mail: blankm@iel.org

Making State and Local Partnerships Work

When Head Start programs work on health concerns with state and local partners, their efforts can benefit families who need access to information about health care and health delivery systems. Forming these links and working jointly with cooperating organizations can lead to a history of shared decision making while improving families' access to health care. These links also can help to decrease or eliminate duplication of services.

The Role of Head Start-State Collaboration Offices

Head Start-State Collaboration Offices play an important role in planning and implementing partnerships with agencies that can provide information about and access to health care at the state and local levels.

The staffs of these offices can be effective liaisons to:

- Governor's offices;
- State and local groups planning special initiatives to help low-income families with health issues;
- State planning and advisory committees working on child health issues;
- State CHIP and state Medicaid agencies;
- Groups planning health awareness campaigns; and
- The wide variety of organizations that address the concerns of low-income people at state and local levels.

These efforts are extremely valuable. They can build important and lasting relationships, can foster work on shared projects, and have the potential to overcome barriers to communication. Collaboration Office staffs have worked to ensure the coordination of Head Start services with health care in many states. Recent examples include:

> **Oregon**: The Collaboration staff worked with the Oregon Health Plan (CHIP) administrators and managers and the Family Health Insurance Program to increase Head Start parent and staff access to health care. Head Start programs served as outreach stations for date stamping health insurance applications, and Head Start convened a round table on the topic of access to health care to followup the recommendations of a focus group.

Alaska: The collaboration staff supported Head Start staff and parents' participation in the CHIP state planning process and served on a CHIP steering committee. The director has contributed to the Alaska Children's Health Plan and Denali KidCare (state CHIP program), and serves on the CHIP advisory board. The Director also set up training by the state CHIP director for all Head Start directors and others attending a recent Alaska Head Start Association meeting on the Denali KidCare program.

Oklahoma: The Collaboration office provided information on Oklahoma's CHIP plan to the state Head Start Association and attended a state meeting held by the Oklahoma Health Care Authority to discuss the CHIP plan. The office also participated with the regional office staff in training on CHIP and explored opportunities for Head Start to be involved in community outreach.

Kansas: This Collaboration Office participated in the development of Health Wave, the Kansas CHIP program. The staff planned and carried out integrated training on this CHIP initiative for Head Start health coordinators, social and rehabilitation services supervisors and case managers, and child care providers.

These activities have offered the staffs of Collaboration Offices an opportunity to communicate an understanding of the needs of the Head Start population, demonstrate a willingness to work cooperatively, and modify agreements when needed. Their demonstrated skills can assist Head Start programs; their successes can inspire Head Start program staff to take the initiative to help families by finding community partners who will work toward effective solutions to health care problems.

Providing State Plan Input

One example of potentially effective action is working with state CHIP planning committees and State Title V advisory committees as participants in the state planning and plan modification process.

Title V advisory committees have helped states to successfully implement the Medicaid and Title V partnerships required by federal law, especially in the areas of outreach, enrollment, standards, and monitoring activities. State Title V programs working with Medicaid are contributing to CHIP outreach efforts using the expertise they developed conducting outreach to pregnant women. Additionally, HRSA's Title V Bureau works closely with states and has developed a performance measurement system for Title V state plans and annual reports. These may serve as models-for CHIP systems and reports.

Many states have prepared CHIP state plans and received funding, but quite a few of them have since modified or intend to modify their original design to improve CHIP services. States may revise their Medicaid and CHIP plans annually, and usually there is an opportunity for public comment, either in writing or at a hearing. Head Start programs can find out how to get involved in their state's planning process by contacting their Head Start-State Collaboration Office, their state Medicaid or CHIP office, their state Head Start Association, or their regional Quality Improvement Center.

Head Start staff members can provide valuable input into the state planning process by explaining the needs of Head Start children, providing examples of past barriers to services, and offering assistance in drafting modifications to state plans that tailor services to the needs of low-income families in the state. They also can seize opportunities to emphasize Head Start's willingness to coordinate activities with other service providers.

While working on state plans, Head Start staff can discuss:

- The unique needs of children enrolled in Early Head Start for early screening and frequent health examinations;
- The concerns affecting American Indians and the involvement of the Indian Health Service;
- Residency requirements and their effect on migrant Head Start children and their families;
- The importance of comprehensive coverage for Head Start children with disabilities; and
- The critical need for dental coverage.

Head Start programs also can provide state officials with data collected for program management and planning purposes. This data includes information about enrolled children with or without health insurance, the number of children enrolled in Medicaid, the health needs of Head Start children, and the health status of enrolled children. Those who draft state plans are often interested in reviewing this type of data, since it helps them prepare provisions meeting the needs of the children in the state. Title V programs can be a valuable partner in this process. Forming relationships with those who draft and modify state plans can lead to further opportunities to amend the plans in future years to meet the needs of Head Start's changing population.

Helping the State Fulfill Program Objectives Cooperatively

Head Start programs may be successful in working with state offices on special initiatives to improve children's health. For example, Head Start-State Collaboration staff members have worked to streamline the enrollment process for children and families in state health programs by simplifying applications for Medicaid and CHIP. This type of work may entail drafting and signing a memorandum of understanding or another agreement between two or more offices after designing improvements. Signing a written agreement is advisable, since it formalizes the process, offers a good reference tool, and ensures that the agreement stays in place, even if the staff changes.

In some Head Start families income fluctuates and the children may be required to switch between the state CHIP and Medicaid programs. Head Start staff members can ensure that states understand how this may adversely affect Head Start families. Presenting this information may help state officials realize the importance of simplifying health benefit applications and improving the enrollment process. It may also help them grasp the need for continuity of care for services offered by both programs.

Another example of a project that streamlines service delivery is cooperating with state officials to have applications for Medicaid and CHIP collected at Head Start centers. Head Start staff can also support state efforts to pursue the possibility of presumptive eligibility, work on public awareness campaigns, develop publications about health care and health care curricula, and offer training about Medicaid and CHIP at Head Start programs. These efforts may also strengthen outreach, which is discussed in the next chapter. Many of the model summaries in Chapter 3 demonstrate how Head Start can effectively link with state partners.

Working with Community Health Care Providers

To ensure that the needs of children are met, Head Start Program Performance Standards require that Head Start grantees establish ongoing collaborative relationships with community health care providers (including dentists, mental health providers, nutritional service providers, hospitals, and clinics).

Head Start staff can use the community assessment and consult the Health Services Advisory Committee to identify community providers and resources. Designated Head Start staff members can then contact these providers for the purpose of establishing liaisons and working on partnerships.

Sharing Information with Partners

In some instances, it may be necessary to share information about Head Start families with organizations planning to assist these families with health, education, or other services. Head Start has a policy of guarding the confidentiality of information about the people it serves, since sharing data about families can be a sensitive issue.

For the purpose of assisting families, Head Start staff can exercise good judgment and waive the confidentiality rules in certain well-defined instances. For example, many partners agree that offering streamlined and simplified applications for health services assists families. In some collaborations, this may necessitate opening Head Start records to other agencies working at Head Start offices or relying on Head Start information to verify facts in applications. If families grant written permission for the release of this information, there should not be any barrier to waiving confidentiality for this purpose.

The key to making this process effective is using the proper forms to obtain consent. An acceptable form must include statements indicating that the family grants informed consent for use of certain information. The staff must ensure that an authorized family member signs the correct space on the form.

The Health Services Advisory Committee can recommend state and local partners for this type of collaboration, and can offer suggestions about preparing effective forms. It can also advise Head Start programs about what data to share to ensure that projects result in effective collaborations. Appendix 6 includes examples of forms containing waivers of confidentiality now in use by Child Nutrition Programs. The waiver language on these forms can serve as a model for Head Start programs developing similar waivers.

Chapter 2

Reaching out to Families

Chapter Highlights

The important outreach role for Head Start

- ***Informing Head Start families about Medicaid and CHIP and connecting them to health information and services***
- ***Identifying typical barriers to service***
- ***Serving the special needs of the Head Start population***

The value of outreach partnerships

- ***Understanding the importance of forming partnerships***
- ***Seeking reimbursement for outreach services***

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Both Medicaid and CHIP have enormous potential to improve dramatically the health of children living in the United States by fulfilling their promise of comprehensive health care and early screening for millions of eligible children.[9] The fact that government programs designed to improve children's health have public support was demonstrated by the results of a survey of Americans shortly after the Balanced Budget Act of 1997 created CHIP. However, in spite of the positive outcome of the survey, results also indicated that the public was not aware of the new legislation on children's health insurance. Less than 30 percent of the parents surveyed said they had read or seen anything about the new health insurance for children.[10]

The federal government has made a concerted effort to publicize CHIP and Medicaid and to encourage Americans to learn about state programs, to educate others, and to become involved in efforts to reach children who need health care. Federal and state officials have also formed partnerships with the private sector to raise public awareness of Medicaid and CHIP. As a result:

- States have installed toll-free numbers to direct families to their state enrollment centers;
- Private foundations have made significant contributions to children's health outreach efforts; and
- Corporate and advocacy organizations have made efforts to reach out to uninsured children.

The legislation authorizing CHIP requires that state plans describe how each state will perform outreach to families of children likely to be eligible for assistance and how these families will be informed about health insurance and enrollment.[11] Outreach for CHIP now incorporates the best practices of Medicaid, as well as thoughtful innovations to improve outreach strategies.

The Outreach Role of Head Start

Informing Head Start Families about Medicaid and CHIP

The National Center for Health Statistics compared insured to uninsured children and found that uninsured children are five times more likely not to have a regular provider of care. During the period they examined, uninsured children were four times as likely to have needed medical or surgical care and been unable to get it, five times as likely to have needed dental care and been unable to get it, and one and a half times as likely to be missing all or some of their immunizations.[11] This information reinforces the importance of Head Start priorities to offer preventive health care and to secure a medical home for Head Start children.

When Head Start enrolls children, staff members have an opportunity for Medicaid and CHIP outreach and referral. The income information provided by families alerts staff to the need to encourage enrollment in Medicaid or CHIP.

Head Start programs' outreach strategies may include:

- Describing the state-specific available health services under Medicaid's EPSDT services or the state CHIP program;
- Working with the Medicaid agencies to have on-site eligibility workers at Head Start parent meetings;
- Promoting the advantages of preventive care, early detection, and treatment;
- Telling families how to enroll and assisting them in enrolling;
- Describing ways to participate; and
- Explaining the available health services, including mental health services.

Some Head Start families may believe that children must be receiving welfare benefits to be eligible for these health services. Head Start staff can explain that Medicaid and CHIP health services are available for children in non-welfare low-income families, including families with working parents. Explaining this fact clearly can link more children to the health services they need.

Linking Head Start Families to Health Information and Services

After programs identify families who may be eligible for Medicaid and CHIP, Head Start programs may take the following steps:

1. *Inform families about Medicaid and CHIP by:*
    - Conducting health education campaigns and health fairs targeted specifically to those who may be eligible for Medicaid and CHIP services;
    - Contacting pregnant women and new parents involved in Early Head Start about the availability of Medicaid and CHIP prenatal and well-baby care programs and services;

- Obtaining and distributing posters, brochures, booklets, and easily understood, multilingual educational materials about Medicaid's EPSDT services and the state's CHIP program;
- Informing families about new outstationed sites for enrollment and flexible enrollment hours, if available, and providing directions to the sites;
- Directing individuals to the local medical assistance office to apply for Medicaid or CHIP, if applications are not available at the Head Start program; and
- Providing information on other options, such as applying by telephone or using mail-in applications.

2. *Explain the Medicaid and CHIP eligibility process to prospective applicants by:*

- Gathering information needed for the application and eligibility determination, including resource information and other health insurance coverage or available health insurance, in preparation for submitting a formal Medicaid or CHIP application; and
- Assisting in assembling the necessary documents for Medicaid or CHIP eligibility determinations.

3. *Help families complete Medicaid and CHIP applications by:*

- Familiarizing them with the basic application;
- Making or referring families for presumptive eligibility determinations (which some states authorize Head Start programs to make) in states that have selected this option;
- Initiating the Medicaid and CHIP application process, and helping with re-determinations. (If there is an agreement with state officials, Head Start may combine its income evaluations with a preliminary Medicaid and/or other state health insurance eligibility screening.)
- Asking families if they were enrolled or denied.
- If families were denied, providing them with the necessary assistance to reapply and become enrolled.

4. *Help families obtain services by:*

- Making appropriate health care referrals;
- Helping families schedule appointments and arrange transportation, and contacting children and families by telephone, through personal letters, or on home visits;
- Helping children and their families use Medicaid and CHIP health resources and navigate the health care system effectively and efficiently; and
- Assisting families in accessing and navigating Medicaid and CHIP managed care systems. This may require a second enrollment step and Head Start staff may be able to help families with this process.

Addressing Barriers

Studies have described barriers to the participation of families in Medicaid resulting in low enrollment numbers.[13] Although CHIP is a new health insurance program and is directed to low-income families, most of whom are working, it is reasonable to assume that some of the same barriers exist in CHIP and must be overcome. Additionally, parents who are working after a period of receiving public assistance may not want to join a health insurance program they perceive as carrying the stigma of public assistance.

In a study of why families did not use Medicaid's EPSDT program, low-income parents mentioned problems in the following three areas:

1. Competing family or personal issues and priorities, such as arranging care for other children or family members, taking time off from work to enroll, managing personal problems, or handling family crises;
2. Barriers in the health care system, such as inconvenient clinic hours or long delays in obtaining appointments; and
3. Problems with outreach efforts, such as not receiving material, inability to understand the material, or not remembering what was in the material.

Parents who did manage to overcome these problems encountered additional barriers, such as scheduling and transportation difficulties, or medical care that they believed was unresponsive to their health needs or insensitive to their culture, practices, and beliefs.

Another recent report described important cultural barriers to U.S. health care that have undermined health care in low-income communities for years. These barriers include communication differences, differences in health practices and beliefs, fear and mistrust of health care institutions, and a lack of knowledge about how to navigate the health care system.[14]

Head Start staff can work in partnership with Medicaid and CHIP to reduce or eliminate these barriers. Effective strategies are described below.

Serving the Needs of the Head Start Population

Head Start staff members become well acquainted with the families they serve. As staff members work to educate parents about their central role in ensuring their children have good health, they can emphasize the importance of using the services offered by Medicaid and CHIP.

Staff members who develop a relationship with families with infants and toddlers can discuss their concerns and help them solve problems they have arranging their schedules to make time for appointments. The staff can help them make appointments and explain the information about health insurance and health delivery in their state. These families may need help planning child care to ensure that the infants and toddlers receive the frequent medical check-ups they require. The staff also can remind the parents of the youngest members that frequent health check-ups and immunizations are not only available, but also critical to their child's healthy development.

Head Start staff can help families overcome language barriers, determine if cultural differences are causing problems, and help families understand and overcome those problems. For example, a migrant family may encounter language and scheduling problems. Head Start staff can work with the family to ensure the members receive translated material, if necessary, and to make appointments when the family is available, such as evenings and weekends. Also, since Head Start staff members are sensitive to the strong cultural traditions of American Indian Head Start families, they can help these families with problems they may encounter in health delivery.

Finally, the families of children with disabilities have special challenges. If the children are enrolled in Head Start, the staff can explain the importance of planning to meet the special needs of these children and help the families locate the services their children are entitled to receive. The staff members can also help to ensure that these families are treated sensitively by those in the health care field, particularly if the family's culture is misunderstood or not represented.

Outreach Partnerships–Federal, State, and Local

Because there are many federal, state, and local initiatives supporting outreach, Head Start will have numerous opportunities to work with others to develop and improve outreach strategies to reach Head Start families eligible for Medicaid and CHIP. Partners can identify the barriers to outreach and enrollment and work together to overcome them. They can also determine what types of information and outreach are the most effective and share this information.

The Health Care Financing Administration is posting state outreach information on Web pages: http://www.hcfa.gov/init/outreach/outhome.htm, http://www.hcfa.gov/init/children.htm, and http://www.insurekidsnow.gov. Other helpful Web sites containing outreach information are listed in Appendix 5.

The Importance of Forming Links

To avoid duplicating existing community outreach programs, Head Start programs should identify what is already being done and find creative additions to link their programs with Medicaid and CHIP. A good starting place is to contact the state Medicaid programs listed in Appendix 4.

Maternal and Child Health (MCH) Title V programs are required to conduct a needs assessment, and they may have useful information on health care needs and resources. The regional office MCH contacts are listed in Appendix 5.

Partnership with Title V programs can help to improve the health of all women, children, and adolescents. Title V can facilitate coordination with other key health programs, such as WIC, immunization, oral health, HIV programs, and health programs in schools and community health centers. Title V Maternal and Child

Health/Children with Special Health Care Needs programs also can identify and facilitate linkages with other child and family programs. These include not only Head Start and child care, but also programs for early intervention, special education, family preservation and support, food, housing, and employment.

Head Start's community assessment will provide useful information. The Health Services Advisory Committee is also a reliable source of information about community outreach. Committee members may have specific suggestions about which organizations should link to strengthen Medicaid and CHIP outreach. They may have access to effective outreach strategies used in other communities that may be well suited to the community they serve.

Potential partners for outreach programs include school districts, community-based organizations, local health and human service providers, and child care centers. Federal and state governments, private businesses, foundations, and advocacy groups also are collaborating to develop and expand effective outreach initiatives. Two examples are the Supplemental Nutrition Program for Women, Infants and Children (WIC) and state child care offices. They may be interested in conducting both joint community education activities about Medicaid and CHIP eligibility and services and coordinated outreach activities.

Also, when Head Start conducts parent workshops about Medicaid and CHIP, it is in the best interest of community health providers to invite non-Head Start parents, WIC parents, and child care parents. This type of invitation can lead to a strong working relationship with the local staff of these groups.

The following chapter will describe outreach strategies that can be adapted to meet the needs of many communities. Contact persons who may provide further assistance are listed at the end of the chapter.

Payment for Providing Outreach Services

Under the Medicaid program, state Medicaid agencies (SMAs) are allowed to claim outreach as an administrative expenditure. The federal government provides matching funds to states for conducting specific Medicaid and CHIP outreach activities.

In order to be reimbursed for performing outreach activities, Head Start must have a contract with the SMA. Rates for performing outreach activities are set by the SMA, which will establish the conditions of reimbursement with Head Start programs. See Appendix 2 for details about reimbursement and Appendix 4 for a list of contacts.

Chapter 3

Partnerships in Action: Strategies that Work

Chapter Highlights

Identifying and using outreach strategies

- *Obtaining information about outreach strategies*
- *Adopting HCFA's effective strategies*
- *Forming Head Start partnerships for outreach success*

What makes outreach strategies work

- *Using administrative tools to help outreach efforts*
- *Serving populations better through outreach*
- *Using resources effectively*

Contacts for Head Start outreach projects who can discuss:

- *Implementing the strategies*
- *Adapting the strategies for your community*

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Discovering how best to work with partners requires patience and time. With prior knowledge about successful outreach strategies, partners can plan much more effectively.

The Head Start-State Collaboration Offices and the Head Start Quality Improvement Centers are good sources of information about effective outreach strategies used by Head Start programs throughout the country. Head Start programs should contact representatives from these offices for up-to-date information about successful outreach. Appendix 6 lists the Head Start-State Collaboration Offices.

The list of Web sites in Appendix 5 is another valuable reference for information about strategies.

Outreach Strategies

The Health Care Financing Administration (HCFA) has described effective outreach strategies for reaching children who may be eligible for EPSDT and CHIP on two Web sites:

http:// www.hcfa.gov/init/outreach/outhome.htm and
http://www.hcfa.gov/init/children.htm.

Following are examples of promising outreach strategies suggested by HCFA to the states and explanations of how Head Start programs work as partners with state and local offices to implement these strategies.

1. *Streamline the eligibility process and offer simplified application forms.*

   Head Start involvement and enthusiasm in discussions about these options can further state implementation at the local level.

   Queen Anne's County Maryland: A simplified application relying on self-declaration of income is in use. Once qualified, families are referred through the Maryland Children's Health Program (MCHP) to WIC nurses who can answer questions about services, and to Healthy Start for services to pregnant women and newborn babies. This method ensures that families receive the services they need without reapplying to participating programs.

Head Start staff in the county work through an informal agreement with the county health department to conduct outreach for MCHP. Head Start informs participating families about MCHP, uses the simplified application on-site, and includes speakers who discuss MCHP at parent and staff meetings held at Head Start. These cooperative outreach efforts have been very effective in raising county enrollment in MCHP.

2. *Allow applications to be sent by mail.*

Head Start can encourage the state to adopt this option and can suggest that families mail applications when the option is available.

Pinellas County Head Start Program, Florida: The state assessed the population of uninsured children and found that over 550,000 children were eligible for Medicaid or CHIP health insurance. The state designed its CHIP program, KidCare, as an umbrella program offering public and private insurance in one affordable and comprehensive plan.

One appealing aspect of the plan is the simplified mail-in application designed and implemented through the Department of Children and Family Services. Head Start assisted with the development of this form and is involved in outreach through an informal agreement with the health department. The application is available through Head Start offices, as well as many other locations in the state.

3. *Allow presumptive eligibility for families in certain programs.*

Head Start's interest in presumptive eligibility and involvement in state plan development can encourage the use of this option in states.

Puerto Rico: All Head Start children in Puerto Rico qualify for free health services through Puerto Rico's Health Reform. A formal agreement linked Puerto Rico's heath care agency with Head Start, and this presumptive eligibility allows families to obtain a Medicaid card within 30 to 60 days. The policy has dramatically improved health services for children.

4. *Develop and distribute outreach information about child health insurance programs that is written simply and appropriately in languages used by the intended audience.*

Head Start can encourage states to prepare culturally appropriate material and can ensure that the available material is used to reach families.

Kentucky Children's Health Insurance Program (KCHIP): Because of the state's growing Hispanic population, special outreach and service strategies are directed to this group. More than 20 public health departments have programs in place to meet the medical needs of the Hispanic population.

Head Start is part of the broad state coalition planning outreach efforts. The Collaboration Office is involved in outreach across the state and supports a grant made to the University of Kentucky to coordinate outreach efforts.

5. *Provide enrollment at local sites.*

By working with state officials, Head Start can ensure that they are aware of Head Start's interest in on-site enrollment.

Kno Ho Co Head Start, Glenmont, Ohio: In November 1997, Head Start staff attended a conference held to inform agencies about CHIP Phase One in Ohio, later called Healthy Start Insurance. They learned that Head Start would be allowed to complete health insurance applications for this program and send them, along with required information, to the Department of Human Services.

Subsequently, staff learned how to conduct health insurance outreach and complete the health insurance application forms. They began outreach in Holmes County through Head Start centers or while on home visits. The Department of Human Services advised Head Start to order health insurance applications directly from a warehouse, and agreed to reimburse Head Start's expenses for outreach and referral. The agreement was informal but was confirmed by a letter from a county office.

Head Start approached two other Ohio counties about conducting outreach and received permission to do so. However, outreach and referral are conducted in these two areas without reimbursement for expenses, because there is no official agreement between the parties at this time. It is significant that Head Start will assist any family in the three counties to apply for health insurance, not solely Head Start families.

6. *Develop outreach strategies with local community-based organizations and have them assist in outreach efforts.*

Head Start staffs sit on many committees devoted to developing outreach in local communities.

Connecticut's Healthcare for UninSured Kids and Youth (HUSKY): This program provides access to health insurance for all uninsured children regardless of family income. Families with incomes under 185 percent of poverty receive the full Medicaid benefit package, and those over 185 percent but under 300 percent of poverty are charged co-payments; some are charged premiums. Those families over 300 percent of poverty pay group premiums and co-payments.

In Connecticut, the group overseeing communication about HUSKY is Healthy Child Care Connecticut. The Head Start-Collaboration Office director sits on a leadership team of Healthy Child Care Connecticut, including a Core Committee that meets quarterly and pulls together 50 representatives of health and early childhood provider organizations. This close partnership with Healthy Child Care has enabled Head Start representatives to work on outreach and other materials supporting HUSKY. One recent success is the development of a model memorandum of understanding between Head Start and managed care organizations (MCOs). It has been adopted by a number of MCOs and will help Head Start coordinate services for families and help families to navigate the system. Workshops for Head Start families and staff are also planned for this purpose.

Michigan's MiChild (CHIP) Program: The Head Start-State Collaboration Program and the Michigan Head Start Association have formed a Michigan Head Start Managed Care Council. This group has researched eligibility and application information and distributed it to Head Start agencies statewide. It meets periodically and work with the Department of Community Health to ensure that Head Start is represented in Medicaid policy planning meetings.

The Managed Care Council has developed streamlined health verification forms specific to Head Start needs for physicians' use, and has coordinated training on the changes in health insurance for children in the state. It has developed a very successful outreach tool for EPSDT, a slide rule showing the components available to children depending on their ages. Now it is seeking more physicians to serve children eligible for EPSDT.

7. *Use trained, trusted persons within the local community to conduct outreach and to assist their neighbors in completing application forms.*

Head Start is respected in local communities, and families rely on health advice offered by Head Start staff.

Indiana's Hoosier Healthwise: In July of 1998, the state of Indiana initiated its CHIP program and enrolled 106 percent of the target population, 42,479 children, by February 1999. This effort relied on 450 enrollment centers across the state. Families enrolled at Head Start centers, hospitals, schools, day care centers, community action programs, child care settings, clinics, HUD offices, and other agencies by using a simplified application form. Each county was awarded grant money to develop local community-based outreach and enrollment efforts.

The enrollment centers in Indiana sign a memorandum of agreement with the local Office of Family and Children and agree to take all potential applicants, even those not affiliated with the enrollment center itself. Most of the 42 Head Start program offices in the state are enrollment centers. Applications completed at the centers are forwarded and entered in the Indiana Client Eligibility System. Enrollment centers keep track of completed applications and the length of time for processing and also find the answers to questions for families to help speed up the process.

Head Start programs conduct outreach in search of potential enrollees and actively recruit for Hoosier Healthwise. In addition, every family in Head Start has a family partnership plan that includes identified needs. If those needs include any support service in the community, the Head Start staff work with the family to connect members to the service. Every family entering Head Start also receives a community resource handbook.

8. *Destigmatize Medicaid by using posters that reflect a positive image of Medicaid and those who use Medicaid.*

In some cases, Head Start programs develop their own flyers about health insurance. This material conveys the importance of health insurance to children and a positive picture of EPSDT. Kno Ho Co Head Start in Glenmont, Ohio, has developed flyers in use in three Ohio counties for outreach. (This Head Start program is also listed in item 5 above.)

Tips for Successful Outreach Partnerships

Partnerships can thrive when efforts are made to address administrative, service, and resource needs creatively. The Head Start programs cited in this chapter worked with state officials to improve outreach efforts in their states. They used the following methods to ensure success in administration, service delivery, and use of resources:

Administration

- Set clear goals, with children's access to quality health services as the primary goal.
- Participate on advisory councils, boards, and other committees planning outreach.
- Plan frequent meetings of partners to strengthen communication.
- Be willing to work without formal agreements, but plan jointly and communicate well.
- Seek grants for outreach projects or develop other funding sources.
- Be willing to adapt methods used in one area for use in another.

Service

- Be flexible and adjust space expectations to needs of the families, including making services available on evenings and Saturdays.
- Be willing to coordinate Head Start enrollment with enrollment in other programs serving the Head Start population.
- Conduct eligibility and enrollment at places families frequent.
- Tailor outreach methods to the needs of the community.
- Eliminate duplication of services.

Resources

- Pool the resources of partners.
- Plan and conduct joint training.
- Teach staffs to communicate well and to overcome inevitable frustrations.

Contact List

Call the following people for information about Head Start outreach projects in this chapter.

Connecticut
Grace Whitney, Governor's Collaboration for Young Children
Phone: 860-424-5066
E-mail: grace.whitney@po.state.ct.us
Project: Participating on a committee developing outreach materials

Florida
Peggy Messenger, Head Start Health Coordinator
Phone: 727-547-5925
Project: Head Start's use of simplified application

Indiana
Donna Hogle, Head Start-State Collaboration Director
Phone: 317-233-6837
E-mail: dhogle@fssa.state.in.us

Lauren Polite, Legislative Liaison, state contact
Phone: 317-232-1149
E-mail: lpolite@fssa.state.in.us
Project: Head Start's role in a statewide system of enrollment centers

Kentucky
Kurt Walker, Director, Head Start-State Collaboration Office
Phone: 502-564-3010
E-mail: kwalker@kih.net
Project: Use of culturally appropriate materials

Maryland
Christina Burke, Shore Up! Inc. Project Head Start
410-827-3258
Project: Cooperation on use of simplified application form

Michigan
Sandra Little, Head Start-State Collaboration Program
Phone: 517-335-3610
E-mail: littles@state.mi.us
Project: Participating on committees coordinating state-level policy and training activities on health insurance for children

Ohio
Tammy McGinnis, Health Services Specialist, Kno Ho Co Head Start
Phone: 330-377-4567, Ext. 17
Projects: Completing health insurance applications and planning outreach

Puerto Rico
MaryJo Doran Gelabert, Executive Director, Head Start Collaboration Project
Phone: 787-721-7000, ext. 2614 or 2615
Project: Head Start's involvement in presumptive eligibility

Appendix 1

Head Start and Health Services

Highlights

A. *Head Start and Early Head Start*

B. *Head Start Health Services*

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A. Head Start and Early Head Start

Head Start

Head Start is a national program that provides comprehensive developmental services for low-income, preschool children ages three to five and social services for their families. Approximately 1,400 community-based nonprofit organizations and school systems have developed unique and innovative programs to meet specific needs. Head Start began in 1965 in the Office of Economic Opportunity.

The Department of Health and Human Services, Administration for Children and Families (ACF) oversees Head Start. Grants to conduct Head Start programs are awarded to local public or private, nonprofit or for-profit agencies by the ten ACF Regional Offices and the Head Start Bureau's American Indian and Migrant Programs Branches mentioned below. At least 10 percent of the enrollment opportunities in each program must be made available to children with disabilities.

Migrant Programs Branch. Migrant Head Start is administered from the national level through local and regional grantees. It is designed to provide comprehensive services to children from birth to compulsory school age in eligible mobile and seasonal farm worker families. The migrant families typically:

- Meet the annual Head Start poverty income guidelines;
- Earn at least 51 percent of their annual income from agricultural work; and
- Change their place of residence at least once within each 24 consecutive months.

Head Start staff tailor health services to the needs of these families. Head Start may schedule health appointments before the migrant families arrive at sites and make night and weekend appointments to accommodate the family work schedules. They also assist families in arranging follow-up care at their new location.

The Migrant Health Program works with Head Start staff and other public health service programs to meet the needs of migrant families. Children in migrant families may be eligible for Medicaid and CHIP.

American Indian Programs Branch. American Indian programs are administered centrally from Washington, D.C. Federally recognized tribes, consortia, and Alaska native corporations are the grantees that operate the 174 Head Start/Early Head Start programs. They vary in size, geography, and population and operate in 26 states.

Head Start has a long-standing collaborative partnership with the Indian Health Service. Tribal health departments provide treatment, referrals, or payments for medical and dental health care, or for related services. In some cases, managed care organizations are responsible for Indian health care.

Early Head Start

In 1994, the Head Start Reauthorization Act established Early Head Start to assist low-income families with infants and toddlers, including children with disabilities, and pregnant women. Participants receive the same comprehensive child development education, health, nutrition, and mental health services as Head Start families. Infants and toddlers develop rapidly and therefore require frequent attention. For example, during the first months of life, infants are assessed every 2 months. The Early Head Start staff serves as advocates and liaisons to service providers for the pregnant women they serve.

Program sponsors include Head Start grantees, school systems, universities, colleges, community mental health centers, city and county governments, Indian tribes, community action agencies, child care programs, and other nonprofit agencies. Early Head Start projects must coordinate with local Head Start programs to ensure continuity of services for children and families.

B. Head Start Health Services

The Philosophy of Head Start Health Services

When Head Start first began, voluntary community health providers offered many health services on site in Head Start programs, such as immunizations and medical and dental treatment. Since then, however, Head Start programs have changed how service is delivered by placing an emphasis on partnerships with providers. These partnerships enable Head Start to respond to modifications in the health care delivery system and the needs of Head Start families.

Currently, in order to comply with the Head Start Program Performance Standards and to best meet the needs of families, programs design their services to take into account a variety of factors, including the results of the community assessment. Programs then determine whether to be a provider of direct health services, a broker of health services, or some combination of the two.

The focus of Head Start health services is to prevent health problems whenever possible by carefully addressing the needs of enrolled children. Successful partnerships are the key to the success of this approach. When conditions or illnesses are found, they are addressed quickly with the help of competent health care partners in an effort to improve the health of the child and to prevent future problems.

Some services Head Start programs provide to parents include:

- Assistance in finding a medical home;
- Locating sources of funding for health services;
- Working with local Medicaid and CHIP agencies to determine a child's eligibility for medical assistance;
- Tracking health services; and
- Offering health promotion activities, including information about well child care and training and information on child health and development.

Performance Standards Requirements for Health Services

1. *Medical Home*

When a child's health status is determined, Head Start staff members make an effort to coordinate health services with families. They strive to ensure that each child has a source of continuous, accessible, coordinated care that serves as a "medical home."

The Head Start Performance Standards requirement for a community assessment offers an opportunity for staff to identify and evaluate what health services are available locally. This activity:

- Supports efforts to find each child a medical home;
- Enables families to carry out future efforts to ensure health care; and
- Assists the staff to meet the goal of offering broad preventive health care.

In cases in which there is not a continuous source of health care, staff will plan strategies to help a family acquire a medical home. These include:

- Determining the values and beliefs of families regarding preventive health maintenance for family members;
- Assisting families in applying for Medicaid or CHIP services;
- Working with local Medicaid and CHIP agencies to determine a child's eligibility for medical assistance and to identify Medicaid and CHIP providers;
- Seeking help from the Health Services Advisory Committee, explained below, to identify potential providers, sources of funding for health services, and ways to inform community health providers about the health needs of Head Start children and families; and
- Helping families get appointments with medical providers.

Once a medical home is located, staff periodically review health records to ensure that recommended treatment and preventive services are being provided, and that providers make plans for both treatment and follow-up.

Performance Standard Requirement

Section 1304.20(a)(i): In collaboration with the parents and as quickly as possible, but no later than 90 calendar days from the child's entry into the program, make a determination as to whether or not each child has an ongoing source of continuous, accessible health care. If a child does not have a source of ongoing health care, grantee and delegate agencies must assist the parents in accessing a source of care.

2. *Well-Child Care Visits*

In addition to ensuring that Head Start families find a medical home for their children's care, Head Start staff encourage well child care visits. Since health care in Head Start requires family involvement, Head Start staff members are expected to emphasize to parents the importance not only of finding a health care provider, but also of scheduling future preventive and primary health care. Only continuous care will identify and address problems quickly.

Performance Standard Requirement

Section 1304.20(a)(1)(ii) (B): For children who are up-to-date on an age appropriate schedule of well child care, grantee and delegate agencies must ensure that they continue to follow the recommended schedule of well child care.

Well-child care includes scheduled age-appropriate preventive and primary health care including medical, dental, and mental health care. The staff can obtain a useful schedule for this care from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program of the Medicaid agency of each state through the Health Department. The Centers for Disease Control and Prevention issues immunization recommendations. The Indian Health Service also provides guidelines for well child care.

3. *Tracking Health Progress*

One aspect of health service management is taking steps to assist children needing further examination and treatment. The goal is to complete health services treatment and follow-up by the end of the program year. To accomplish this, the responsible staff member checks regularly with parents and staff to determine the status of examinations and treatments and the status of immunizations and diagnostic testing.

Performance Standard Requirement

Section 1304.20(a)(1)(ii) (C): Grantee and delegate agencies must establish procedures to track the provision of health care services.

The Head Start staff member responsible for tracking a child's health care works with all of the staff in contact with the family to ensure that health records are carefully reviewed. The staff may be at the center, in a family child care setting, or may be home visitors. To assist in this process, health professionals are urged to explain procedures carefully and sensitively to families.

Head Start staff members also tell parents how to utilize the referral procedures necessary to obtain health care services. For example, a child with a heart condition will require the services of a specialist, and a referral to that doctor from the primary care provider may be required before the visit can be arranged.

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In order to track health care services, staff must maintain child health records. The records include the results of any examination and treatment plan and indicate progress in completing treatment for all conditions requiring follow-up. Records are reviewed with parents and are confidential. Head Start also facilitates transitions for families and transfers a child's health records to the next location if families move or when the child is no longer enrolled in Head Start.

4. *Screening*

Purpose: When a child enrolls in Head Start, steps are taken to assess the child's health quickly to identify any health concerns. The emphasis is on scheduling preventive and primary health care. The screening also enables staff and partners to ensure prompt intervention to address problems. For example, it can identify children who need further assessment to determine if they need vision services or hearing aids, mental health services, dental treatment, special education, or other related services.

Performance Standard Requirement

Section 1304.20(b)(1): In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate screening procedures to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual and emotional skills. To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background.

The screening procedures must be sensitive to the child's cultural, linguistic, and developmental background. Head Start also expects parents to be involved in the health care process, since they have the primary, long-term responsibility for their children's health.

The screening process is particularly important for children with disabilities. Some children who enroll in Head Start have previously identified disabilities and must be scheduled for immediate services. Other children with disabilities are identified during the screening process and need urgent intervention or care. Head Start works with community partners to locate services available for children who need care for disabling conditions.

Cooperative Agreement: The Department of Health and Human Services and the Department of Education, through the Federal Interagency Coordinating Council, have developed a cooperative agreement for coordinated screening. These efforts make timely screening feasible and also make it possible to expedite immunizations by making them available during the screening process. Coordinated screening also provides an excellent parent education opportunity, since information about child development, preschooler behavior, and services such as WIC, Medicaid, and CHIP can be made available to families while their children are screened.

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Timeframes: A child's health must be screened for developmental, sensory, behavioral, hearing, and vision problems within 45 days after entry into the program, and the child's health status must be determined by a health care professional within 90 days of entry. Head Start's health partners in community agencies may offer some direct services, such as providing screenings on site. In many cases, additional community interventions are appropriate to ensure that the child's progress is adequately supported.

There are special provisions about screening and assessment for programs that do not operate for 90 days, such as those serving migrant farm workers and their families. In those locations, the screening and assessment of children must take place within 30 days from the child's entry into the program. This necessitates:

- Scheduling health services before or during the first weeks of the program;
- Obtaining records from other states and programs; and
- Arranging night and weekend appointments to accommodate migrant work schedules.

Agencies attempt to make a determination of health status earlier than the suggested timeframe, particularly for rapidly developing infants and toddlers. In some cases, to expedite delivery of health care, staff members help enrolled families find health care before the child actually enters the program by participating in spring or summer screening programs before fall opening sessions.

5. *Parent Involvement in Health*

Performance Standard Requirement

Section 1304.40(f)(1): Grantee and delegate agencies must provide medical, dental, nutrition, and mental health education programs for program staff, parents, and families.

Parents are principally responsible for maintaining the health and nutrition of their children. They can establish healthy habits in the home and find health, nutrition, and mental health services if they are educated about and involved in these matters.

Grantee and delegate agencies provide education programs for parents and families on medical, dental, nutritional and mental health. The staff convey information using expert guest speakers, hands-on experiences, and newsletters. The programs are designed with parent attitudes, cultures, languages, beliefs, fears, and educational levels in mind. The staff also use community resources and consult with the Health Services Advisory Committee (refer to 7 below) when developing programs.

The medical and dental health education program must assist parents in understanding how to enroll and participate in a system of ongoing family health care,

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rather than relying on emergency rooms. Agencies provide names and addresses of providers and information about after-hours care and how to obtain medical advice by telephone. The staff encourage parents to apply for Medicaid or CHIP health benefits and to keep the child connected with a medical home after the child leaves Head Start (refer to 1 above).

The staff encourage parents to become active partners in their children's medical and dental health care and to accompany their children to appointments, provide emotional support, and request explanations of medical conditions and procedures. If the schedule of working parents limits their availability for appointments, staff seek night clinics or services at nontraditional times. Parents are encouraged to model healthy behaviors by going to doctors and dentists themselves.

Parents are offered the opportunity to learn about preventive care, emergency first aid, hazards, safety practices, and general health information, and are taught to detect signs of health problems. The staff offer nutrition education, and parents discuss the nutritional status of their child with the staff. Mental health professionals assist parents in promoting a positive mental health environment for children and train them to recognize stress and other risk factors, and how and when to ask for help. The staff offer group opportunities for parents to share experiences and develop solutions to problems with their children, and also provide individual opportunities for confidential discussions about mental health. Efforts are made to acquaint mental health professionals with family concerns and cultural issues.

6. Ongoing Collaborative Relationships

Agencies are encouraged to form partnerships with health care, mental health, and nutritional services organizations, including local health departments, community health centers, managed care organizations, medical or dental schools, and professional associations. The Health Services Advisory Committee (see item 7 below) can offer information about providers and resources in the community.

Grantee and delegate agencies' discussions with state, tribal, and local officials can lead to local collaborations. Other resources for families include local elementary schools, libraries and museums, providers of child care services, and any other organization or business that provides support and resources to families. Collaborations with local elementary schools and child care providers can support successful transitions between Head Start and other child care settings and Head Start and elementary schools. In addition, child care collaborations can involve joint training; multiple

Performance Standard Requirement

Section 1304.41(a)(2): Grantee and delegate agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs and to ensure that Early Head Start and Head Start programs respond to community needs.

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funding sources for full-day services; shared facilities, resources, and equipment; and coordinated use of transportation.

Services obtained through the local educational agency or another agency for education services to children with disabilities are arranged through a written agreement.

Finally, agencies contribute to community efforts to prevent and treat child abuse and neglect by collaborating with local child abuse prevention programs and with agencies serving children and families affected by physical, emotional, or sexual abuse and neglect, and seek service providers familiar with the culture and language of the families concerned.

7. *Health Services Advisory Committee*

A critical component to Head Start's preventive health care system is the local Health Services Advisory Committee (HSAC). This committee includes Head Start parents and staff, health and human services professionals, and other community volunteers who are representative of the racial and ethnic groups served by the local Head Start program. Head Start programs may invite representatives from Medicaid, CHIP, and managed care organizations in the community to participate in HSAC. The committee members meet at least twice each year to discuss program issues in the medical, dental, mental health, nutrition, and human services fields.

Performance Standard Requirement

Section 1304.41(B): Each grantee directly operating an Early Head Start or Head Start program, and each delegate agency, must establish and maintain a Health Services Advisory Committee which includes Head Start parents, professionals, and other volunteers from the community.

This advisory committee assists in the development of health policies and procedures and supports Head Start's objective to provide continuous and accessible health care for children and families. its members are knowledgeable about prevalent community health problems and can respond to questions from Head Start staff about strategies to address these problems. The HSAC provides guidelines regarding:

- Accessing health, dental, and mental health services;
- Iron deficiency anemia, including hematocrit/hemoglobin;
- Standards for prenatal care;
- Tuberculin and lead testing schedules;

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- Dental visit schedules and services;
- Water fluoridation, fluoride used topically, and other dental services;
- Testing and preventive measures for community health problems, including sickle cell anemia, intestinal parasites, fetal alcohol syndrome/effect, baby bottle tooth decay, head lice, and hepatitis A;
- Immunizations in addition to those already scheduled;
- The adequacy of local EPSDT services; and
- Medication administration and staff physicals.

In addition, HSAC can contribute to the community assessment by responding to questions about the following: the availability of local providers, including managed care providers; changes in Medicaid; the implementation of CHIP; sources of funding for local health services; and ways to inform community health providers about the health needs of Head Start children and families.

Appendix 2

Medicaid and CHIP Health Insurance

Highlights

A. Medicaid and EPSDT

B. The State Children's Health Insurance Program (CHIP)

C. Comparison of Medicaid and CHIP

This Appendix explains how Medicaid and CHIP are designed and how they affect beneficiaries, including Head Start children and their families. For more specific information about Medicaid and CHIP in a particular state, refer to the state contacts listed in Appendix 4.

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A. Medicaid and EPSDT

Early and Periodic Screening, Diagnostic, and Treatment Services

Medicaid, Title XIX of the Social Security Act, provides medical assistance for certain individuals and families with low incomes and resources. Medicaid eligibility is based on family size and family income. The program became law in 1965 as a jointly funded cooperative venture between the federal and state governments to help states provide adequate medical care to eligible needy persons. Children who meet the income guidelines and qualify for Head Start are typically eligible for Medicaid services. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines provided by the federal government, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment Services) is the child health component of the Medicaid program. Under EPSDT, states are required to provide a broad range of medical and support services to eligible children under age 21. In addition, states must perform certain activities, such as informing eligible children and their families about EPSDT and reporting data annually to HCFA.

The term EPSDT describes the program's goals and the services that it covers:

Early: Assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic: Assessing children's health at key points to assure continued healthy development;

Screening: Using tests and procedures to determine if children screened have conditions requiring closer medical or dental attention, including attention for mental health problems;

Diagnostic: Determining the nature and cause of conditions identified by screenings and those requiring further attention; and

Treatment: Providing services needed to control, correct, or reduce physical and mental health problems.

Services Covered Under Medicaid's EPSDT

States must submit a state plan which eventually becomes the contract between HCFA and the state. Each state's plan will list covered services. Like other health insurance programs, state Medicaid programs sometimes limit the type of covered services or the duration of the service. However, these limits do not apply to children. For example, Medicaid-eligible children may receive health services that may not be covered in the state plan for adults, such as dental services. States are required to cover the following services under the EPSDT component:

- Screening services, the core of the EPSDT benefit package. They must include:
    - A comprehensive health and developmental history; including a physical and mental health assessment;
    - A comprehensive unclothed physical examination;
    - Appropriate immunizations according to the schedule of the Advisory Committee on Immunization Practices (ACIP);
    - Laboratory tests that may include blood lead level; and
    - Health education, including anticipatory guidance.
- Dental services, including restoration of teeth and maintenance of dental health;
- Hearing services, including hearing aids;
- Vision services, including eyeglasses;
- Any other necessary health care diagnostic services and treatment that Medicaid would cover, whether or not the service is covered under a particular state's Medicaid plan, to correct or improve illnesses and conditions found in screening; and
- Assistance with transportation and scheduling of appointments.

Screening services must be available in accordance with a state's timetable (periodicity schedule) and should be available at times other than the regularly scheduled intervals, for occasions when illness is suspected or a condition is found that did not exist or was not identified at the regular periodic screening.

Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation. The purpose of diagnosis is to determine the nature, cause, and extent of the problem found by the screening examination. This diagnosis may then result in development of a plan for treatment.

Treatment services are covered whenever they are medically necessary to correct or improve defects, physical or mental illnesses, or other conditions discovered through an EPSDT screening.

EPSDT treatment services include all mandatory and optional services available under the Medicaid program. Some optional Medicaid services that are mandatory for EPSDT include case management, physical therapy, rehabilitative services, and private duty nursing, provided that the services are medically necessary.

Two New Medicaid Service Provisions

The Balanced Budget Act of 1997 included two new provisions giving states the option to increase children's health care coverage through the Medicaid program:

1. Presumptive Eligibility for Low-Income Children

   Certain health and child development professionals considered "qualified entities" may enroll children under 19 years of age in Medicaid temporarily if they appear to be eligible based on their ages and family income. Qualified entities may include children's traditional health care providers, such as pediatricians and health professionals who deliver services in community health centers. Qualified entities may also include WIC programs, Head Start programs, and state and local agencies that determine eligibility for subsidized child care under the Child Care and Development Block Grant (CCDBG) Act.

   This temporary enrollment is called presumptive eligibility. It can be a particularly useful tool for enrolling children in Medicaid who are not receiving public assistance and whose parents are employed at low-wage jobs not offering health insurance coverage, since verifying the parents' income could cause a delay in enrollment.

2. Twelve-Month Continuous Eligibility

   This provision allows states to guarantee up to 12 months of coverage to children enrolled in Medicaid. This is allowed even if the family income or other circumstances change during the 12-month period in a way that might make the child ineligible for Medicaid.

Eligible Children Under Medicaid's EPSDT

Most children under age 21 who are eligible for Medicaid are eligible to receive EPSDT services. Family income is the main criterion used to determine Medicaid eligibility. When a child is determined to be Medicaid-eligible, information is given to the family regarding EPSDT services. The family has the option to utilize these services or not. EPSDT services are always available to a child, whether a family chooses to use EPSDT initially or at a later date.

Children under age 21 may qualify within a variety of groups, including:

- Infants under age 1 and children under age 6 in low-income families whose earnings are at or below 133 percent of the federal poverty Level (FPL), or a higher percentage in several States that have expanded eligibility.
- All children under age 19 born after September 30, 1983, in families with incomes at or below 100 percent of the FPL. This phased-in coverage ensures that all children under age 19 in such families will be covered by October 1, 2002. A number of states have already expanded eligibility to all children under age 19 and/or to a higher percentage of poverty.
- Beneficiaries of Supplemental Security Income (SSI) in most states. The new children's health legislation requires states to continue Medicaid coverage for all disabled children who were receiving SSI on August 22, 1996, but who lost their SSI eligibility as a result of the 1996 changes in the definition of a child with a disability.
- Beneficiaries of adoption assistance and foster care under Title IV-E of the Social Security Act.

In many cases, Head Start and Early Head Start children will qualify for Medicaid, including children of migrants and American Indian children. Some states provide coverage to additional groups beyond the mandated provisions. Head Start staff should ensure they understand state policies so all entitled children receive benefits.

Head Start children with disabilities may also qualify to receive SSI.

Providers of Medicaid EPSDT Services

Ideally, EPSDT services are part of a continuum of care in which someone who is familiar with the child's health history and family situation always delivers the child's health care services. EPSDT services may be provided by a physician, nurse practitioner, pediatrician, or other type of health care provider who is certified by the state Medicaid program to be a Medicaid provider.

States cannot limit EPSDT providers to only those who can provide all EPSDT diagnostic and treatment services. If more than one provider is needed to complete the full range of EPSDT services to a child, these services should be coordinated to ensure that the child receives all the necessary services and to avoid duplication.

However, most children who have a family health care provider will receive most of their EPSDT screening, diagnostic, and treatment services from the same provider. Services may be furnished by qualified providers located in child care and Head Start programs, school-based health centers, state and local health departments, managed care organizations (MCOs), physicians' offices, hospitals, Indian Health Service clinics, community health centers, federally qualified health centers, and rural health care clinics.

The Individuals with Disabilities Education Act (IDEA) provides for special education services in the schools. Part B of IDEA is designed to ensure that school-aged children with special education needs receive a free, appropriate public education. Under Part B, schools must prepare an appropriate Individualized Education Plan (IEP) for a child with special needs specifying all of the special education and related health services needed by the child. Part C of IDEA is the early intervention program for infants and toddlers. Each child receiving special education services has an Individualized Family Service Plan (IFSP) which details the services the child needs. Medicaid can pay for some health-related services required under the IFSP.

Medicaid Managed Care

Managed care organizations (MCOs) are also providers of Medicaid EPSDT services. The significant shift from individual providers to managed care plans makes it essential that affiliated programs understand the relationship between the Medicaid program and MCOs.

An MCO is a health system that combines the delivery and financing of health care services. Managed care also refers to a system in which an individual primary care provider coordinates all care, including referrals to specialty services. It represents an arrangement among the state Medicaid agency (SMA), the Medicaid beneficiary, and health services providers. MCOs offer many medical specialties and services for their members. They have the potential to offer increased access to preventive and primary health care for those who are enrolled.

Although there are many types of managed care arrangements, the delivery and financing of services have general characteristics. To receive services, most patients must be enrolled with a primary care provider who is responsible for the coordination of care. Primary care physicians furnish patients with access to selected provider networks in which services are coordinated. The services focus on prevention and early detection of illnesses and health conditions. The MCOs establish a provider network, pay providers, and educate providers and enrollees about the covered services available under the plan.

Varying degrees of coordination between MCOs and Head Start programs are possible. It is important to establish a relationship with MCOs as early as possible if

Head Start children are enrolled. The state agency and/or the MCO may reimburse the Head Start program for providing outreach, such as health education campaigns and other administrative services to families and children. This is discussed further in Chapters 4 and 5.

To find out more about special arrangements a state may have with MCOs, contact the state's Medicaid agency (see Appendix 4) or visit the HCFA Web site: http://www.hcfa.gov/init/statepln.htm/.

The State Agency Responsible for Medicaid

A state Medicaid agency (SMA) is responsible for Medicaid in each state. SMAs are often part of a larger network of social service agencies and health programs for children and families. Coordination among these entities is essential to maximize access to services and to prevent duplication. Medicaid agencies are required to coordinate with Title V Maternal and Child Health (MCH) programs and the Supplemental Nutrition Program for Women, Infants, and Children (WIC). They also are encouraged to coordinate with Head Start agencies and other entities. These collaborative efforts may include interagency agreements, cross-referrals, service on Head Start advisory committees, and other partnership activities designed to ensure health care for children.

In their Medicaid programs, states are required to:

- Seek out eligible children and families to:
  - Encourage their participation in Medicaid;
  - Inform them of the availability and benefits of preventive services;
  - Provide assistance with scheduling appointments and transportation; and
  - Help families use health resources effectively and efficiently.
- Assist families in finding EPSDT providers;
- Assure that providers assess health needs through initial and regularly scheduled periodic examinations; and
- Assure that detected health problems are diagnosed and treated early before they become more complex and their treatment more costly.

Payment for Medicaid Services

SMAs are responsible for paying for medical and certain supportive medical services covered under the state plan and provided to Medicaid beneficiaries. Services are also provided under waivers. Each SMA establishes its state-specific rates, which usually are available to any qualified provider who agrees to provide the service.

Federal funds are available to match states' expenditures for Medicaid services at a rate, referred to as the federal medical assistance percentage (FMAP), which varies by state. In accordance with a formula specified in Medicaid law, each state's FMAP is based on the state's per capita income. (States with a lower per capita income have a higher FMAP.) It may vary from a statutory minimum of 50 percent to a statutory maximum of 83 percent. Allowable expenditures for medical services include screening, diagnosis, and treatment.

Federal funds are also available to match states' Medicaid administrative expenses for certain activities such as outreach, eligibility determinations, provider relations, some transportation activities, and follow-up. In general, the federal match rate for these administrative expenditures is 50 percent. However, other Medicaid administrative expenses may be matched at rates 75 percent or higher, depending on the category.

Reimbursement for Outreach Services Obtained under Medicaid

The federal Medicaid program provides 50 percent federal financial participation (FFP) for general administrative expenses, including outreach. Under the Medicaid program, there is no cap on the amount of the FFP available for states' claims for administrative expenditures.

B. The State Children's Health Insurance Program (CHIP)

For more information on CHIP, contact the HCFA regional office that serves your state (see Appendix 5) or visit the HCFA Web site: http://www.hcfa.gov/init/children.htm.

Services Covered Under CHIP

Under CHIP, the state can choose to provide child health assistance to low-income, uninsured children through:

- A separate insurance program;
- A Medicaid expansion; or
- A combination of these two approaches.

If a state chooses to offer a separate insurance program, there are four benefit options from which to choose:

The Balanced Budget Act of 1997 (BBA) created Title XXI of the Social Security Act referred to as the State Children's Health Insurance Program (CHIP). Its primary focus is to provide health insurance coverage for low-income uninsured children. It also offers new opportunities for low-income families who are not income-eligible for Medicaid to have health insurance protection for their children under a state program.

1. *Benchmark coverage including:*
    - The standard Blue Cross/Blue Shield preferred provider options offered to federal employees;
    - Any health benefits coverage plan offered and generally available to state employees; or
    - The MCO plan that has the largest commercial, non-Medicaid enrollment in the state.
2. *A benchmark equivalent which must include:*
    - Inpatient and outpatient hospital services;
    - Physician's surgical and medical services;
    - Laboratory and x-ray services; and
    - Well-baby and well-child care, including age-appropriate immunizations.
3. *Existing comprehensive state-based coverage (FL, NY, PA); or*
4. *Secretary-approved coverage — any other health benefits coverage that, upon application by a state, the Secretary of HHS approves as providing coverage for the population of targeted low-income children.*

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Under CHIP, a state may choose to provide a period of presumptive eligibility and assure a 12-month eligibility period.

Eligible Children Under CHIP

CHIP targets low-income children and defines them as under 19 and living in families with incomes at or below 200 percent of poverty, or a level up to 50 percentage points higher if the state currently provides Medicaid to children in families with incomes over 150 percent of poverty. Thus, if a state Medicaid agency covers children to 180 percent of the federal poverty level, then CHIP coverage could be extended to children at or below 230 percent of the federal poverty level.

Children eligible for Medicaid must be enrolled in Medicaid and are not eligible for CHIP. Also, to be eligible for CHIP, children cannot be covered by other group health insurance.

Children are also excluded if they are inmates of a public institution or patients in institutions for mental diseases, or children who are members of families eligible for health benefits on the basis of a family member's employment with a state public agency.

In some cases, Head Start children and the children of Head Start staff will be eligible for CHIP, depending on state eligibility levels. Head Start staff should learn how their state handles CHIP eligibility to ensure coverage of eligible children, including migrants and American Indian and Alaskan Native children. Eligibility for CHIP is not affected by the fact that American Indian and Alaskan Native children may be eligible for receiving health care services funded by the Indian Health Service.

Providers of CHIP Services

As in Medicaid, services may be furnished by qualified providers located in child care and Head Start programs, school-based health centers, state and local health departments, hospitals, managed care organizations (MCOs), physicians' offices, Indian Health Service clinics, and community health centers. The state plan will describe the state's method for assuring quality and appropriateness of care.

As discussed above under Medicaid, the Individuals with Disabilities Education Act (IDEA) provides for special education services in the schools. Part C of IDEA is the early intervention program for infants and toddlers. Each child receiving special education services has an Individualized Family Service Plan (IFSP) which details the services the child needs. CHIP may pay for some health-related services required under the IFSP, depending on the state's plan. Check with the responsible state agency for details about this matter.

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The State Agency Responsible for CHIP

If the state chooses a Medicaid expansion, the state Medicaid office will generally oversee Medicaid services, including EPSDT requirements. Refer to pages 63 for a list of requirements. However, if the state initiates a separate CHIP program, it may name another agency as responsible. Contact the state by calling the toll free number listed in Appendix 4 to determine the state agency with oversight. The state Medicaid offices are also listed in Appendix 4.

Payment for CHIP Services

Federal funds are available for matching states' CHIP expenditures at a rate, referred to as the enhanced federal medical assistance percentage (enhanced FMAP). This varies by state. In accordance with a formula specified in CHIP law, each state's enhanced FMAP is equal to 70 percent of the state's Medicaid FMAP plus 30 percent. (The state's Medicaid FMAP is the matching rate for states' medical service expenditures under the Medicaid program.) However, the enhanced FMAP cannot exceed 85 percent. For example, if a state's Medicaid FMAP was 50 percent, the CHIP enhanced FMAP would be 65 percent (70 percent of 50 percent, or 35 percent, plus 30 percent).

States may also impose cost-sharing charges (premiums, deductibles, copayment, coinsurance, or similar fees) on CHIP beneficiaries up to the cost-sharing limits specified in the Balanced Budget Act. The limits are intended to spare patients from incurring large costs.

Reimbursement for Outreach Services Obtained under CHIP

Up to 10 percent of a state's total expenditures for CHIP can be used for outreach, direct services, other children's health initiatives, and reasonable administrative costs.

If a state chooses to expand children's health insurance under Medicaid instead of establishing a separate CHIP program, the state may, at its option, claim federal financial participation (FFP) for its outreach expenditures under its general Medicaid program at the 50-percent FFP rate. Alternatively, the state may claim for outreach related to the Medicaid CHIP expansion at the enhanced federal matching percentage. Also, if a state conducts joint outreach efforts for the Medicaid CHIP expansion program and the CHIP program, it may bill these expenses to either Medicaid or CHIP.

C. Comparison of Medicaid and CHIP

MEDICAID*	CHIP
Entitlement: All eligible may receive benefits.	**Capped Entitlement:** Targets low-income children. Serves those who are income eligible within the limits of available funds.
Eligibility: Children under age 6 living in families with incomes under 133 percent of poverty and older children up to age 19 born after 9/30/83 in families with incomes under 100 percent of poverty, plus a variety of other groups of children specified in the text. Some states have expanded eligibility beyond these minimums. Provisions for presumptive eligibility and 12-month continuous eligibility now apply.	**Eligibility:** Children eligible for Medicaid must be enrolled in Medicaid and are not eligible for CHIP. CHIP targets low-income children and defines them as under age 19 and living in families with incomes at or below 200 percent of poverty or a level up to 50 percentage points higher if the state currently provides Medicaid to children in families with incomes over 150 percent of poverty. States may provide presumptive eligibility and 12 months of continuous eligibility.
Immigrants: Qualified aliens exempt from the limitations on eligibility contained in Welfare Reform, including refugees, asylees, those with deportation withheld under Section 243(h) of the Immigration and Naturalization Act (INA), certain active-duty military and veterans, their spouses and unmarried dependent children, and lawful permanent residents with 40 quarters of Social Security coverage, must be covered. Refugees, asylees, and those with deportation withheld under Section 243(H) of the INA are exempt from limitations on eligibility for 7 years from the date of entry to the U.S. Other qualified aliens defined in Section 431 of Welfare Reform may be provided Medicaid at state option, if they entered the U.S. before	**Immigrants:** The same rules apply, with one exception. Those qualified aliens subject to the 5-year bar from receiving benefits are not eligible for CHIP.** There is no CHIP eligibility for nonqualified aliens.

MEDICAID*	CHIP
8/22/96. After that date, most qualified aliens are barred from receiving benefits for 5 years from entry, except those subject to the 7-year rule. Nonqualified aliens are eligible only for Medicaid.**	
Area: Must be statewide.	**Area:** State option to select the area; does not have to be statewide.
Benefits: National EPSDT benefit package.	**Benefits**: Vary by state and based on benchmark plans.
Providers: Services may be furnished by qualified providers located in child care settings and Head Start programs, school-based health centers, state and local health departments, hospitals, managed care organizations (MCOs), physicians offices, Indian Health Service clinics, community health centers, federally qualified health care centers, and rural health care clinics.	**Providers:** Services defined by the state may be furnished by qualified providers located in child care settings and Head Start programs, school-based health centers, state and local health departments, hospitals, managed care organizations (MCOs), physicians offices, Indian Health Service clinics, community health centers, federally qualified health care centers, and rural health care clinics.
Pre-existing conditions: Services are offered for pre-existing conditions.	**Pre-existing conditions:** If a states chooses to provide coverage through a group health plan or group health insurance coverage, the plan may impose a pre-existing condition exclusion. This exclusion is not permitted to extend for more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date, and could be imposed only for conditions diagnosed or treated within the 6 months prior to enrollment. However, the period of any such pre-existing condition exclusion must be reduced by the number of days of creditable coverage as of the enrollment date, as counted under section 2701(a)(3) of the PHS Act.

MEDICAID*	CHIP
Premiums: None for categorically targeted low-income eligible children.	**Premiums:** At or below 150 percent of the federal poverty line (FPL), up to maximum amounts allowed under Medicaid regulations. Above 150 percent of the FPL, may be imposed up to the cumulative cost-sharing cap of 5 percent of a family's total income.
Cost sharing: None for services to children.	**Cost sharing:** None for preventive services. At or below 150 percent of the FPL, up to the nominal amounts consistent with Medicaid. Above 150 percent of the FPL, may be imposed up to the cumulative cost-sharing cap of 5 percent of a family's total income.

*If a state chooses to expand the Medicaid program with CHIP funds, all Medicaid rules apply.

** Any aliens who receive either CHIP or Medicaid will not have their receipt of such benefits used by the Immigration and Naturalization Service (INS) in a public charge determination. The exception to this rule is receipt of long-term care services for other than short-term rehabilitation under Medicaid.

Appendix 3

Intra-Agency Agreement

Intra-Agency Agreement between the Health Care Financing Administration, Medicaid Bureau and the Administration, for Children and Families, Head Start Bureau and Child Care Bureau

Signed 1995

I. Purpose and Goals

The purpose of this Agreement between the Health Care Financing Administration (HCFA) and the Administration for Children and Families (ACF) is to improve outreach to and the overall health of entire families through enhanced access to quality medical care and preventive services. The Medicaid, Head Start, and Child Care Bureaus share similar program goals: To ensure that low-income children have a medical home and to increase the Medicaid enrollment and participation rates for eligible children and families.

The goals of this Agreement are: 1) to establish and/or improve local, state, regional and national collaboration between ACF and HCFA; 2) to increase the Medicaid enrollment and participation rates of children enrolled in Head Start and Child Care; and 3) where appropriate, to increase the number of Head Start programs and/or Child Care providers that are also Medicaid providers.

II. Authority

This Agreement is made under the authority of Reorganization Plan No. 1 of 1953, 5 U.S.C. Appendix and 42 USC 9831 et seq. , The Head Start Act as amended May 19,1994. The Social Security Act provides for sharing health resources under jurisdiction of the Secretary and encourages cooperative efforts. Section 6581(a)(1) of the Child Care and Development Block Grant provides for the coordination of all activities of the Department of Health and Human Services relating to child care, and, to the maximum extent practicable, coordination of such activities with similar activities of other Federal entities.

Section 402(g)(7) of the Social Security Act states that activities in subsection 402(g) (which provides for AFDC child care and Transitional Child Care) and subsection 402(i) (which provides for the At-Risk Child Care program) shall be coordinated in each state with existing early childhood education programs in that State, including Head Start programs funded under chapter 1 of the Education Consolidation and Improvement Act of 1981, and school and nonprofit child care programs (including community-based organizations receiving funds designated for preschool programs for handicapped children).

III. Background

History

The Medicaid Bureau, HCFA, and the Head Start Bureau, ACF, have a long history of collaboration. In 1976 and again in 1980, HCFA, and the then Office of Human Development Services (OHDS) entered into agreements to collaborate on the use of Medicaid by Head Start enrollees. The purpose of these agreements was to facilitate collaboration between Head Start and Medicaid so that eligible children received Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) services. Eight activities were identified in previous agreements for joint efforts: outreach or case finding, informing families about EPSDT services, scheduling assistance, establishing uniform medical screening periodicity standards, provider resource development, establishing uniform medical screening components, providing transportation to medical services, and determining information sharing. Agreements were implemented on a national, regional, and state level, and were supported by Regional training and technical assistance staff who assisted Head Start grantees in negotiating local agreements. Section 6401 of the Omnibus Budget and Reconciliation Act (OBRA) of 1989, Pub. L. No. 101-239 expanded Medicaid eligibility to include pregnant women and children age 0-6 whose income is up to 133 per cent of the federal poverty level. It is estimated that over 90 per cent of children enrolled in Head Start and Child Care are Medicaid eligible due to this expansion.

Medicaid

The Medicaid program was created in 1965 under Title XIX of the Social Security Act. It is administered by HCFA; however, each State designs and administers its own Medicaid program, setting eligibility, service coverage and payment standards within broad Federal guidelines. As a result, there is wide variation among States' Medicaid programs. The EPSDT service has been a part of the Medicaid program since 1969. It is the mandatory and comprehensive preventive child health component of Medicaid, and requires States to provide screening services, immunizations, dental, vision, and hearing services to Medicaid eligible people under the age of 21. In addition, States must provide other necessary health care, diagnostic services, treatment, and any other measures found to be medically necessary and which are covered under Medicaid, whether or not such services are included in the State plan.

A new program, the Vaccines for Children program, will also provide free vaccines through participating providers to these groups of children: Medicaid eligible, Native American, and uninsured. Children whose insurance coverage does not include vaccines may also receive free vaccines from certain providers. Many Head Start and children enrolled in Child Care are included in these groups.

Head Start

The Head Start (HS) Program was created in 1965 under the Economic Opportunity Act and is based on the premise that all children share certain needs, and that children from low-income families, in particular, can benefit from a comprehensive developmental program to meet these needs. It is administered by the ACF, which directly funds local HS projects. It consists of four integrated components: education, health, parent involvement, and social services. The health component emphasizes prevention, early intervention, parent involvement, and health education, and focuses on medical, nutritional, mental and dental health services. Children enrolled in Head Start are required to receive a thorough medical and dental examination, health screenings within 45 days of enrollment, an immunization assessment, necessary immunization services, and a nutritional assessment after they enter the program. A primary goal of the Head Start health component is to assist the family in securing an ongoing source of medical care when the child leaves Head Start.

In Fiscal Year 1994, 740,493 children were enrolled in Head Start. Most of these children were 3 to 5 years of age. Children 0-3 years of age were served by Migrant Head Start programs, the Parent and Child Centers, and the Comprehensive Child Development Program.

The 1994 Head Start Reauthorization Legislation included a provision for ACF to develop an initiative to serve pregnant women and children age 0-3. This new program, Early Head Start, will begin in 1995. It will provide early, continuous, intensive, and comprehensive child and family development services that aim to enhance child development, support parenting skills, and help parents move toward self-sufficiency. Programs will be designed to address four areas: child development; family development; community building; and staff development. Health and support services will be provided to children and pregnant women. It is expected that most pregnant women and children enrolled in Early Head Start will be Medicaid eligible.

Child Care Bureau

In 1995, the Child Care Bureau was established within ACF to administer the four ACF child care programs: the Child Care and Development Block Grant (CCDBG), and three Title IV-A programs: At-Risk Child Care (ARCC), Aid to Families with Dependent Children Child Care (AFDC-CC), and Transitional Child Care (TCC). The CCDBG and ARCC programs were created by sections 5081 and 5082 of OBRA 1990, Pub. L. No. 101-508 respectively. The AFDC-CC and TCC programs were created by the Title III of the Family Support Act of 1988, Public Law 100-485. Placing the responsibility for all child care programs within this Bureau allows for increased coordination of child care services, enhanced consistency in policy-setting, planning, and reporting across diverse programs as well as streamlined program operations. Child Care assistance in available through the States to families in the following manner:

1) AFDC-CC provides child care to AFDC families who are working or in State-approved education or training programs;

2) TCC provides up to 12 months of child care to working AFDC recipients upon loss of eligibility for AFDC due to increase in earnings from employment;

3) ARCC provides child care to low-income working families that do not receive AFDC but need child care assistance in order to remain employed; and

4) The CCDBG provides child care to low-income families who are working, attending a job training or educational program, or who receive or need to receive protective services. Funding is also available to improve the availability and quality of child care and for early childhood development and before and after-school services.

These programs serve children 0 to 13 years of age and may also serve children up to age 18 or 19 who are under court supervision or incapable of caring for themselves. Data for FY 1993 indicate that the majority of children served by Title IV-A and the CCDBG programs were under age 6. In FY 1993, 67% of the children in CCDBG funded child care lived in families that were at or below the federal poverty level. Another 23% of the children in this program lived in families with incomes between 100 and 150 percent of the poverty level. Children enrolled in AFDC are Medicaid eligible and may also be eligible for Medicaid during the transitional period after the family leaves AFDC.

In FY 1993, Title IV-A funds (AFDC-CC, ARCC and TCC) provided child care for an average of 642,943 children per month. In FY 1993, CCDBG funds were used to provide some portion of child care for 755,904 children.

IV. Scope of Work and Responsibilities

A. *National Collaboration between the Medicaid Bureau (MB) the Head Start Bureau (HSB) and the Child Care Bureau (CCB):*

A HSB/MB/CCB intra-agency workgroup will be established and will conduct regular, preferably semi-annual, meetings to support activities of this agreement, such as:

- Develop a strategic plan with Regional Office (RO) involvement within 3 months of signing this agreement to include specific strategies to assist states, Child Care, and HS programs to increase Medicaid enrollment and participation rates.

- Exchange program information, policy updates, information about conferences, related demonstration projects and approved waivers, and other efforts of mutual interest.
- Develop strategies that will improve MB support of health services provided in HS and child care settings.
- Assist and encourage the development of agreements between managed care entities, HS and/or Child Care programs where appropriate.
- Encourage support of the collaborative efforts described in this agreement through inclusion in the Central Office MB, CCB and HSB work-plans.
- Support and encourage inter-agency and intra-agency collaboration between HSB, CCB, MB, and other agencies of mutual interest including: Department of Agriculture, Department of Education, Environmental Protection Agency, and Public Health Service.
- The HSB will keep the MB informed about the Early Head Start program and will seek MB assistance in developing collaborative strategies to improve access to care for pregnant women and children 0-3 enrolled in the Early Head Start program.
- MB and HSB will direct the development and dissemination of a guide entitled: EPSDT: A Guide for Head Start Programs.
- MB and CCB will direct the development and dissemination of a guide entitled: A Guide to Medicaid and Child Care.
- MB will issue joint information memoranda with HSB and/or CCB that will discuss ways to improve Medicaid outreach activities, case management services and screenings.
- MB, CCB, and HSB will encourage and/or facilitate joint Regional, State, and/or local training and technical assistance events on becoming Medicaid/EPSDT providers.
- MB, HSB, and CCB will work together to promote the development of materials for parents about Medicaid/EPSDT services.
- MB, HSB, and CCB will develop and/or disseminate materials that focus on public health issues of early childhood in collaboration with other agencies.
- MB, HSB, and CCB will encourage the development by State/local programs of joint application processes for multiple services.
- MB, HSB, and CCB will collect and share examples of effective practices and share with Regional Offices.
- MB, HSB, and CCB will explore the possibility of joint demonstration projects on issues related to young children and their families such as improving access to health care, immunizations, and lead poisoning prevention.
- MB, CCB, and HSB will facilitate policy coordination by inviting ACF representatives to attend MB's Maternal and Child Health Technical Advisory Group (MCH-TAG) meetings.
- HSB and CCB will include in any appropriate publications information about accessing health care services, including Medicaid EPSDT and the Vaccines for Children Program.
- HSB and CCB will support and facilitate MB activities established to increase Medicaid enrollment, such as becoming Medicaid providers or conducting outreach.

- MB will include appropriate Head Start and child care topics in its MCH conference calls with Regional Offices for sharing with their states.
- MB, HSB and CCB will identify State/regional/national data sources that can provide information about Early Head Start, Child Care and Head Start participation in Medicaid.
- MB, HSB and CCB will develop a mechanism for ACF to be kept informed about State health care reform and Medicaid managed care efforts that will impact on Medicaid beneficiaries enrolled in Child Care, Early Head Start or Head Start.

B. Regional Collaboration

A HCFA-ACF regional intra-agency workgroup (with representatives from HSB and CCB) will meet regularly, and will consider developing strategies to support activities of this agreement in the following suggested ways:

Develop regional intra-agency agreements and initiatives where they do not exist and update existing agreements and initiatives that are currently in effect.

- Assist State Medicaid agencies' Child Care Programs and HS programs in developing agreements and collaborative strategies with each other.
- Assist and encourage the development of Agreements among managed care entities, HS, and Child Care programs.
- Encourage that the HCFA-ACF Regional work-plans include support of the collaborative efforts described in this agreement.
- Monitor State agreements and provide technical assistance where appropriate.
- Provide information on "Effective practices" to the national workgroup for national dissemination, and to States' Child Care and HS programs.
- Share information on collaborative efforts, demonstration projects, and approved waivers impacting the common population served by both agencies.
- Document Medicaid/HS collaboration on regional Head Start on-site program review instruments (OSPRI) when applicable.
- Encourage the development by State/local programs of joint application processes for multiple services.
- Encourage State Medicaid Agencies to allow a Child Care and HS representative to serve as a full member or ex-officio member of a state's Medical Care Advisory Committee.
- Upon request, the Regional ACF will provide State Medicaid Agencies with data from the HS Program Information Report (PIR) highlighting EPSDT enrollment rates by grantee and by State.

C. Enhancing State/Local Collaboration

The Regional Offices of the HCFA and ACF will assist and encourage the development of State/local agreements to support the activities of this Agreement such as:

- Medicaid agencies can assist HS and/or Child Care programs in becoming Medicaid providers, if permitted by State and Federal law and other regulations.
- Child Care and/or HS programs can work with State/local Medicaid offices to coordinate eligibility identification and determination, and to improve case management and outreach activities.
- Medicaid agencies, HS and Child Care programs can develop strategies that will facilitate information exchange within the constraint of applicable confidentiality regulations.
- Encouraging Medicaid representation on the HS Health Services Advisory Committee and other HS Component Advisory Committee (i.e. Disabilities, Social Services, etc.).
- Encouraging Medicaid representation on a State/local Child Care Advisory Committee or working group.
- HS programs can invite a local Medicaid or Managed Care representative to participate at Head Start Policy Council meetings, Health Fairs, and other parent meetings and events to provide information on Medicaid services.
- Encouraging State and local Medicaid representatives to participate in early intervention meetings to share information on needs, issues and concerns regarding services Child Care and/or HS children and families.
- State and local Medicaid representatives and ACF/HS/Child Care Regional Training/Technical Assistance (T/TA) providers will work together to coordinate and provide workshops and training sessions at State Child Care and local and State Head Start conferences.
- Encourage local Medicaid agencies to participate in HS and/or Child Care recruitment and enrollment activities.
- HS and Child Care programs can collaborate with Medicaid State Agencies to develop and field test new EPSDT enrollment informational materials.
- In States where Medicaid State Agencies are instituting "managed care/coordinated care systems," they can plan and work with HS and Child Care to educate and transition families from fee-for-service to coordinated care options.

V. Duration of Agreement

This agreement, when accepted by both parties, shall become effective immediately. Representatives of both administrations will review the agreement at least annually, to determine progress towards developing State level agreements and the impact of such agreements. Appropriate modifications will be made to reflect the changing environment. Any modification to or termination of this Agreement must be agreed to by both parties in writing.

VI. Evaluation of Agreement

In order to determine the results of this Agreement, HCFA and ACF agree to look at the changes in the enrollment and participation of Medicaid eligible children enrolled in Head Start and/or Child Care.

VII. Contact Persons

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Head Start Bureau

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Child Care Bureau

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Health Care Financing Administration
Medicaid Bureau

Barbara Marmion
Medicaid Bureau
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Baltimore, MD 21207-5187

VIII. Funding

This Agreement does not involve a transfer of funds.

IX. Duplication

Full implementation of this Agreement will not duplicate any existing agreements.

X. Privacy Act

Not applicable.

XI. Signatures:

Olivia A. Golden, Commissioner
Administration on Children, Youth and Families
Signed-7/7/95

Sally Richardson, Director, Medicaid Bureau
Health Care Financing Administration
Signed-8/29/95

Norman Thompson, Chief Financial Officer
Administration for Children and Families
Signed-7/14/95

Appendix 4

State Contacts

Highlights

A. *What's Available in States*

B. *CHIP Contacts*

C. *State Medicaid Offices and Web Sites*

D. *Head Start-State Collaboration Offices*

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A. What's Available in States [15]

State	CHIP	Medicaid	Local Calls Only	Operator Available	Other Languages	Available Materials	Application	Applicant/ Recipient Status Information
Alabama 888-373-KIDS	ALL Kids			X				
Alabama 800-362-1504	X	X						
Alaska 907-273-3240		X						referral to 907-561-2171
Arizona 877-764-KIDS	KidsCare							
Arkansas 888-474-8275	ARKids First		X					
California 888-747-1222	Healthy Families			X	Nine different languages		X	
Colorado 800-688-7777	Family Health Line			X	Spanish & Asian	Brochures	X	
Colorado 800-359-1991	CHP+				Spanish	X	X	
Colorado 800-221-3943	X				Spanish		X	X
Connecticut 877-CT-HUSKY	HUSKY Plan				Spanish		X	
Delaware 800-372-2022	X	X						
District of Columbia 800-666-2229	DC Healthy Families			X	Spanish	Brochures	X	
Florida 888-FLA-KIDS	Florida Kid Care			X	Spanish	X	X	
Georgia 877-GA-PEACH	GA Peach Care for Kids			X			X	X
Georgia 800-766-4456				X				
Hawaii # not available yet			X					

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State	CHIP	Medicaid	Local Calls Only	Operator Available	Other Languages	Available Materials	Application	Applicant/ Recipient Status Information
Idaho 800-926-2588		X		X	Spanish			Referral to area self-reliance office for application
Illinois 800-252-GROW	KidCare		X					
Illinois 800-252-8635		X	X					
Indiana 800-889-9949	Hoosier Healthwise				Spanish		X	
Iowa 800-369-2229	Hawk I			X	Spanish interpreter available	Brochures		Refer to County Human Services Prog for application
Kansas 800-792-4884	Health Wave			X	Spanish	Brochures	X	
Kansas 800-766-9012	X		X					
Kentucky 800-635-2570		X		X				
Louisiana 877-252-2447	LA CHIP			X			X	
Maine # not available	X							
Maryland 800-456-8900	Maryland's Children's Health Program							
Massachusetts 800-841-2900	MassHealth				Spanish		X	
Michigan 888-988-6300	MIChild			X	Spanish and an Asian language		X	X
Minnesota 800-657-3672	Minnesota Care						X	X
Mississippi 800-948-3050	MS's Children's Health Insurance Program							
Missouri 888-275-5908	MC+			X		Brochures	X	

State	CHIP	Medicaid	Local Calls Only	Operator Available	Other Languages	Available Materials	Application	Applicant/ Recipient Status Information
Montana 800-421-6667	MT Kids Insurance				X	Packets of information, pregnancy & child-related brochures	X	
Montana 800-362-8312		X		X				Referral to County Dept of HHS for application
Nebraska 877-632-5437	Kids Connection		X					
Nevada 800-360-6044	Nevada Check Up			X	Spanish		X	
Nevada 702-687-5000			X					
New Hampshire 800-852-3345	Healthy Kids - Gold							
New Jersey 800-701-0710	New Jersey KidCare			X	Spanish	Brochures & enrollment package	X	
New Mexico 888-997-2589		X	X					
New York 800-698-4543	Child Health Plus			X	Spanish, Chinese literature	Flyers, brochures, envelope stuffers		
New York 800-522-5006		X						
North Carolina 800-367-2229	NC Health Choice		X					
North Dakota 800-755-2604		X						Auto attendant for medical services; you can speak to provider relations or secretarial staff
Ohio 800-324-8680	Healthy Start			X	Spanish	Medicaid info provided as well	X	
Oklahoma 800-987-7767	Sooner Care			X	Spanish	Enrollment package	X	
Oregon 800-359-9517	Oregon Health Plan			X	Interpreters available	Information packet; brochures for providers (i.e., hospitals, insurers)	X	

State	CHIP	Medicaid	Local Calls Only	Operator Available	Other Languages	Available Materials	Application	Applicant/ Recipient Status Information
Pennsylvania 800-986-KIDS	PA Children's Health Insurance		X					
Rhode Island 800-346-1004	RiteCare							
South Carolina 888-549-0820	Partners for Healthy Children			X			X	
South Dakota 605-773-4678		X						Economic Assistance Office
Tennessee 800-669-1851	TennCare			X			X	
Texas 800-422-2956	Texas CHIP		X					
Utah 800-662-9651	CHIP		X					
Utah 888-222-2542	Utah's Children's Health Insurance Prog	X		X	Separate language line	Informational literature	X	
Vermont 800-250-8427		X						
Virginia 877-822-6747	VA Children's Medical Security Plan							
Virginia 804-786-7933		X			Spanish		X	
Washington 800-204-6429		X	X					
West Virginia 888-WV-FAMILY	CHIP			X			X	
Wisconsin 800-362-3002		X		X				Refers people to CHIP (608-266-1935)Ask for Angie
Wyoming 307-777-7921		X		X				

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B. CHIP Coordinators: Contact Information

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Outreach

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District Of Columbia Linda Flowers Policy Analyst Department of Human Services 2100 ML King Jr. Avenue, S.E. Washington, DC 20020 (202) 645-5057, ext. 3417	**District Of Columbia** Same as Program Administration
Florida Joyce Raichelson MediKids Program Administration 2728 Ft. Knox Blvd. Building #3 Room 2327 Tallahassee, FL 32308-5403 (850) 922-7313	**Florida** Gail Vail Administrator, Program Development Agency for Health Care Administration 2727 Mahan Drive, Building 3 Tallahassee, FL 32308 (850) 488-9347
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Nevada Christopher Thompson Administrator Division of Health Care Financing and Policy 2527 North Carson Street Carson City, NV 89710 (702) 687-4176, ext. 247	**Nevada** Terry Pozzi Outreach Coordinator Division of Health Care Financing and Policy 2527 North Carson Street Carson City, NV 89710 (702) 687-4176, ext. 245
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Health Policy and Planning
Oklahoma Health Care Authority
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105
(405) 530-3357 (or 3230)

Oregon
Rian Frachele
Department of Human Resources
Human Resources Building
500 Summer Street, N.E., Third Floor
Salem, OR 97310-1015
(503) 945-6588

Outreach

North Dakota
Camille Eisenmann
CHIP Outreach Coordinator
Division of Medical Assistance
Department of Human Services
600 East Boulevard Avenue
Department 325
Bismarck, ND 58505-0261
(701) 328-2321

Ohio
Sukey Barmum
Strategic Planner
Ohio Department of Human Services
30 East Broad Street
Columbus, OH 43266-0423
(614) 728-8476

Oklahoma
Kurt Snodgrass
Public Information Officer
Oklahoma Health Care Authority
4545 North Lincoln Boulevard
Oklahoma City, OK 73105
(405) 530-3484

Oregon
Same as Program Administration

CHIP Coordinators: Contact Information (Continued)

Program Administration

Pennsylvania
Pat Stromberg
Director, PA CHIP
Pennsylvania Insurance Dept.
1345 Strawberry Square
Harrisburg, PA 17120
(717) 705-0009 or (717) 705-4198

Puerto Rico
Margarita LaTorre
Medicaid Director, Office of Economic Assistance to the Medically Indigent
Department of Health, G.P.O. Box 70184
San Juan, PR 00936
(809) 765-1230

Rhode Island
Patricia Leddy
Director, RIteCare
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-2501

South Carolina
Linda Sharkey
Partners for Healthy Children
Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206
(803) 898-2834

Outreach

Pennsylvania
Jeanette Hoffman
Outreach Coordinator, PA CHIP
Pennsylvania Insurance Dept.
1345 Strawberry Square
Harrisburg, PA 17120
(717) 705-0009 or (717) 705-4198

Puerto Rico
Same as Program Administration

Rhode Island
Diana Beaton
Outreach Coordinator, RIteCare
Office of Managed Care
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-2501

South Carolina
Beth Harmon
Outreach Coordinator, Children's Health Programs
Department of Health and Human Services
1801 Main Street, 11th Floor
Columbia, SC 29202-8206
(803) 253-6100

CHIP Coordinators: Contact Information (Continued)

Program Administration

South Dakota
David M. Christensen
Medicaid Director
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3495

Tennessee
Susie Baird
Director of Programs
Bureau of TennCare
Department of Health
729 Church Street
Nashville, TN 37247-6501
(615) 741-0213

Texas
Jason Cooke
Associate Commissioner
Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711
(512) 424-6536

U.S. Virgin Islands
Priscilla Berry Quetel
Executive Director
Bureau of Health Insurance and Medical Assistance
210-3A Altona, Suite 302
Frostco Center
St. Thomas, U.S. Virgin Islands 00802
(340) 774-4624

Outreach

South Dakota
Janet Lehnkuho
Economic Assistance
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-4678

Tennessee
Same as Program Administration

Texas
Randy Fritz
CHIP Bureau Chief
Department of Health
1100 West 49th Street
Austin, TX 78756
(512) 458-7343

U.S. Virgin Islands
Same as Program Administration

CHIP Coordinators: Contact Information (Continued)

Program Administration

Utah
Chad Westover
Administrator, Children's Health
Insurance Program
Department of Health
P.O. Box 141000
Salt Lake City, UT 84114-1000
(801) 538-6982

Vermont
Paul Wallace-Brodeur, Director
Office of Health Access
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201
E-mail: angiet@wpgate1.ahs.state.vt.us
(802) 241-2897

Virginia
Kathryn Kotula, Director
Division of Policy and Research
Department of Medical Assistance
600 East Broad Street, Suite 1300
Richmond, VA 23219
(804) 371-8851

West Virginia
Lynn Gunnoe Sheets
Director, Children's Health Insurance
Program
Bureau of Medical Services
Department of Health and Human
Resources
7012 S.E. McCorkle Ave.
Charleston, WV 25304
(304) 926-1726

Outreach

Utah
Same as Program Administration

Vermont
Ann Rugg
Senior Managed Care Administrator
Office of Vermont Health Access
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201
(802) 241-2766

Virginia
Same as Program Administration

West Virginia
R. Philip Shimer
Deputy Commissioner
Bureau for Medical Services
Department of Health and Human
Resources
Building 3, State Capital Complex
Room 206
Charleston, WV 25305
(304) 926-1700

C. State Medicaid Offices and Web Sites

Alabama
Alabama Medicaid Agency
501 Dexter Avenue, P.O. Box 5624
Montgomery, AL 36103-5624
(334) 242-5010, (800) 362-1504
Fax Number (334) 242-5097
http://www.medicaid.state.al.us

Alaska
Director, Division of Medical Assistance
Department of Health and Social Services
P.O. Box 110660
Juneau, AK 99811-0660
(907) 465-3355
Fax Number (907) 465-2204
http://www.hss.state.ad.us/dma/table.htm

American Samoa
State Medicaid Officer
Department of Health
LBJ Tropical Medical Center
Pago Pago, AS 96799
011-684-633-4590
Fax Number 011-684-633-1869

Arizona
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034
(602) 417-4680
Fax Number (602) 252-6536
http://www.ahccs.state.az.us

Arkansas
Director, Division of Medical Services
Department of Human Services
P.O. Box 1437, Slot 1100
Little Rock, AR 72203-1437
(50l) 682-8292 TDD (510) 682-6789
Fax Number (501) 682-1197
http://www.medicaid.state.ar.us

California
Deputy Director, Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814
(916) 654-0391
Fax Number (916) 657-1156
http://www.dhs.cahwnet.gov/

Colorado
Executive Director, Department of Health Care Policy and Financing
1575 Sherman Street
Denver, CO 80203-1714
(303) 866-2993
Fax Number (303) 866-4411
TDD (303) 866-3883
http://www.state.co.us/
gov_dir/chcpf/index.html

Connecticut
Director, Medical Care Administration
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5116
(860) 424-5116
Fax Number (860) 424-5114
http://www.dss.state.ct.us/
svcs/medical/htm

Delaware
Sr. Director, Medical Assistance Program
Department of Health and Social Services
P.O. Box 906, Lewis Building
1901 North DuPont Highway
New Castle, DE 19720
(302) 577-4901
Fax Number (302) 577-4557

State Medicaid Offices and Web Sites (Continued)

District of Columbia
Deputy Director, Medical Assistance
Administration Department of Health
2100 ML King Jr. Avenue, SE
Suite 302
Washington, DC 20020
(202) 727-0735
Fax Number (202) 610-3209
http://www.dchealth.com/offices.htm

Florida
Director of Medicaid Agency for Health
Care Administration
2727 Mahan Drive, Bldg. 3
Tallahassee, FL 32308
(850) 488-3560
Fax Number (850) 488-2520
http://www.fdhc.state.fl.us/

Georgia
Director, Department of Medical
Assistance
2 Peachtree Street, N.W. Suite 4043
Atlanta,GA 30303-3159
(404) 656-4479
Fax Number (404) 657-5238
http://www.state.ga.us/dma/

Guam
Ms. Ma Theresa Arcangel
Administrator
Bureau of Health Care Financing
Department of Public Health and Social
Services
P.O. Box 2816
Agana, GU 96910
(671) 735-7269
Fax Number (671) 734-6860

Hawaii
Administrator, Med-Quest Division
Department of Human Services
820 Miliani St., Room 606
Honolulu, HI 96813
(808) 692-8056
Fax Number (808) 586-5389
http://www.state.hi.us/icsd/dhs/dhs.html

Idaho
Administrator, Division of Medicaid
Department of Health and Welfare
450 West State St., Second Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5747
Fax Number (208) 364-1811
http://www.state.id.us/dhw/hwgd_www/home.html

Illinois
Administrator, Medical Operations
Department of Public Aid
201 South Grand Avenue, East 3d Floor
Springfield, IL 62763-0001
(217) 782-2570
Fax Number (217) 782-5672
http://www.state.il.us/dpa/

Indiana
Assistant Secretary
Family and Social Services
Administration, Room W382
402 W. Washington Street
Indianapolis, IN 46204-2739
(317) 233-4455
Fax Number (317) 232-7382
E-Mail: kgifford@fssa.state.in.us
http://www.ai.org/fssa/HTML/PROGRAMS/2d.html

State Medicaid Offices and Web Sites (Continued)

Iowa
Director, Division of Medical Services
Department of Human Services
Hoover State Office Building, Fifth Floor
Des Moines, IA 50319-0114
(515) 281-8794
Fax Number (515) 281-7791
http://www.dhs.state.ia.us/HomePages/DHS/medical.htm

Kansas
Commissioner, Adult Medical Services
Department of Social and Rehabilitation Services
Docking State Office Building
Room 628 South
915 S.W. Harrison Street
Topeka, KS 66612
(785) 296-5217
Fax Number (785) 296-4813
http://www.ink.org/public/srs/srsservices.html

Kentucky
Commissioner, Department for Medicaid Services
Third Floor
Americana Building
275 East Main Street
Frankfort, KY 40621
(502) 564-4321
Fax Number (502) 564-3866
http://cfc-chs.chr.state.ky.us/medicaid/medimap.htm

Louisiana
Director, Bureau of Health Services Financing
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821-9030
(504) 342-3891
Fax Number (504) 342-9508
http://www.dhh.state.la.us/

Maine
Director. Bureau of Medical Services
Department of Human Services
State House Station 11
Augusta, ME 04333
(207) 287-2093
Fax Number (207) 287-2675
http://www.state.me.us/bms/bmshome.htm

Maryland
Deputy Secretary for Health Care Financing
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
(410) 767-1432
Fax Number (410) 333-5185

Massachusetts
Commissioner, Division of Medical Assistance
600 Washington Street
Boston, MA 02111
(617) 210-5690
Fax Number (617) 210-5697
http://www.state.ma.us/eohhs/agencies/dma.htm

State Medicaid Offices and Web Sites (Continued)

Michigan
Chief Executive Officer, Medical Services Administration
Department of Community Health
400 S. Pine St.
Lansing, MI 48909
(517) 335-5001
Fax Number (517) 335-5007
http://www.mdch.state.mi.us/mdch2/index_g.htm

Minnesota
Assistant Commissioner, Health Care
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3852
(651) 282-9921
Fax Number (651) 297-3230
http://www.dhs.state.mn.us/

Mississippi
Executive Director, Division of Medicaid
Office of the Governor
Robert E. Lee Building, Suite 801
239 North Lamar Street
Jackson, MS 39201-1399
(601) 359-6056
Fax Number (601) 359-6050
http://www.dom.state.ms.us/

Missouri
Division of Medical Services
Department of Social Services
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
(573) 751-6922
Fax Number (573) 751-6564
http://www.dss.state.mo.us/

Montana
Administrator, Division of Health Policy and Services
Department of Public Health and Human Services
1400 Broadway
Helena, MT 59601
(406) 444-4141
Fax Number (406) 444-1861
http://www.dphhs.mt.gov/

Nebraska
Administrator, Medical Services Division
Nebraska Department of Health and Human Services
301 Centennial Mall South, Fifth Floor
Lincoln, NE 68509-5026
(402) 471-9241
Fax Number (402) 471-9092
http://www.hhs.state.ne.us/med/medindex.htm

Nevada
Administrator, Division of Health Care Finance and Policy
1100 E. William St
Suite 116
Carson City, NV 89701
(775) 687-4176 x. 251
Fax Number (775) 687-5080
http://www.state.nv.us/dhcfp/

State Medicaid Offices and Web Sites (Continued)

New Hampshire
Medicaid Director
Medicaid Administration
Bureau Department of Health and Human Services
6 Hazen Drive
Concord, NH 03301-6521
(603) 271-4353
Fax Number (603) 271-4376
http://www.state.nh.us/dhhs/ohm/ohm_ind.htm

New Jersey
Director, Division of Medical Assistance and Health Services
Department of Human Services
CN-712, 7, P.O. Box 712
Quakerbridge Plaza
Trenton, NJ 08625-0712
(609) 588-2600
Fax Number (609) 588-3583
http://www.state.nj.us/humanservices/dhshc1.html

New Mexico
Director, Medical Assistance Division
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
(505) 827-3100
(888) 997-2583 Toll-free client information
Fax Number (505) 827-3185
http://www.state.nm.us/hsd/

New York
Deputy Commissioner, Department of Health
Empire State Plaza Room 1441, Corning Tower Building
Albany, NY 12237
(518) 474-8646
Fax Number (518) 486-6852
http://www.health.state.ny.us/index.htm

North Carolina
Director, Division of Medical Assistance
Department of Health and Human Services
1985 Umstead Drive
P.O. Box 29529
Raleigh, NC 27626-0529
(919) 733-2060
Fax Number (919) 733-6608
http://www.dhhs.state.nc.us/docs/divinfo/dma.htm

North Dakota
Director, Division of Medical Assistance
Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0261
(701) 328-3194
Fax Number (701) 328-1544
http://www.health.state.nd.us/ndhd/default.asp

Northern Marianas
Medicaid Administrator, Department of Public Health & Environmental Services
Commonwealth of the Northern Mariana Islands, P.O. Box 409 CK
Saipan, MP 96950
(670) 664-4880 or 4882
Fax Number (670) 234-8931

State Medicaid Offices and Web Sites (Continued)

Ohio
Deputy Director, Office of Medicaid
Department of Human Services
30 East Broad Street
31st Floor
Columbus, OH 43266-0423
(614) 644-0140
Fax Number (614) 752-3986
http://www.ohio.gov/odhs/R11.html

Oklahoma
State Medicaid Director
Oklahoma Health Care Authority
4545 North Lincoln Boulevard
Suite 124
Oklahoma City, OK 73105
(405) 530-3439
Fax Number (405) 530-3470

Oregon
Administrator
Senior and Disabled Services Division
Department of Human Resources
500 Summer Street, N.E.
2nd Floor Human Resources Building
Salem, OR 97310-1015
503) 945-5811
Fax Number (503) 373-7823
http://www.omap.hr.state.or.us/

Pennsylvania
Acting Secretary
Department of Public Welfare
Health and Welfare Building, Room 515
Harrisburg, PA 17120
(717) 787-1870
Fax Number (717) 787-4639
http://www.state.pa.us/PA_Exec/Public_Welfare/overview.html

Puerto Rico
Mr. Roberto Hernandez, Medicaid Director
Office of Economic Assistance to the Medically Indigent
Department of Health
G.P.O. Box 70184
San Juan, PR 00936
(809) 765-1230
Fax Number (809) 250-0990

Rhode Island
Associate Director, Division of Health Care Quality
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 462-3575
Fax Number (401) 462-6338

South Carolina
Director, Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206
(803) 253-6100
Fax Number (803) 253-4137
http://www.dhhs.state.sc.us/

South Dakota
Program Administrator
Medical Services, Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3495
Fax Number (605) 773-4855
http://www.state.sd.us/state/executive/social/medicaid/

State Medicaid Offices and Web Sites (Continued)

Tennessee
Director of Operations, Department of Finance and Administration
729 Church Street
Nashville, TN 37247-6501
(615) 741-0213
Fax Number (615) 741-0882
http://www.state.tn.us/commerce/tncardiv.html

Texas
State Medicaid Director
Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711
(512) 424-6517
Fax Number (512) 424-6585
http://www.hhsc.state.tx.us/HP1.html

Utah
Director, Department of Health
Division of Health Care Financing
P.O. Box 142901
Salt Lake City, UT 84116-2901
(801) 538-6406
Fax Number (801) 538-6099
http://hlunix.ex.state.ut.us/medicaid/

Vermont
Director, Office of Health Access
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201
(802) 241-2880
Fax Number (802) 241-2974
http://www.dsw.state.vt.us/

Virginia
Director, Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219
(804) 786-8099
Fax Number (804) 371-4981
http://dit1.state.va.us/~dmas/

Virgin Islands
Director, Bureau of Health Insurance and Medical Assistance
Department of Health
210-3A Altona
Suite 302
Frostco Center
Charlotte Amalie, VI 00802
(809) 774-4624
Fax Number (809) 774-4918

Washington
Acting Assistant Secretary
Medical Assistance Administration
P.O. Box 45080
Olympia, WA 98504-5080
(360) 664-0008
Fax Number (360) 902-7855
http://www.wa.gov/dshs/

State Medicaid Offices and Web Sites (Continued)

West Virginia
Commissioner, Bureau for Medical Services
Department of Health and Human Resources
7012 MacCorkle Avenue, SE
Charleston, WV 25304
(304) 926-1703 (ask for Ms. Lawton's Secretary)
Fax Number (304) 926-1818
http://www.wvdhhr.org/bms/

Wisconsin
Director, Division of Health
Department of Health and Social Services
One West Wilson Street
Room 250
Madison, WI 53701
(608) 266-2522
Fax Number (608) 266-1096
http://www.dhfs.state.wi.us/

Wyoming
Administrator, Division of Health Care Financing
Department of Health
North Building, Room 259B
6101 Yellowstone Road
Cheyenne, WY 82002
(307) 777-7531
Fax Number (307) 777-6964
http://wdhfs.state.wy.us/wdh/medicaid.htm

D. Head Start-State Collaboration Offices

Alabama
Linda Hampton
Alabama Department of Education
50 North Ripley Street
5348 Gordon Persons Building
Montgomery, AL 36104-3833
(334) 242-8294
(334) 242-0496 Fax
lhampton@sdenet.alsde.edu
Web site: www.alsde.edu

Alaska
Marilyn Webb
Head Start-State Collaboration Project
Dept. of Community and Regional Affairs
State of Alaska, P.O. Box 112100
Juneau, AK 99811-2100
(907) 465-4861
(907) 465-8638 Fax
mwebb@ComRegAf.state.ak.us

Arizona
Bruce Astrein
Governor's Division for Children
1700 West Washington, Suite 101-B
Phoenix, AZ 85007
(602) 542-3483
(602) 542-4644 Fax
bastrein@azgv.state.as.us
Web site: www.state.az.us/gv/children

Arkansas
Tonya Russell
Arkansas Head Start Association
Head Start-State Collaboration Project
523 South Louisiana, Suite 301
Little Rock, AR 72201
(501) 371-0740
(501) 370-9109 Fax
headstart@aristotle.net

California
Michael Silver
California Department of Education
Child Development Division
560 J Street
Suite 220
Sacramento, CA 95814
(916) 324-8296
(916) 323-6853 Fax
msilver@cde.ca.gov

Colorado
Lynn Johnson
Office of the Governor
Colorado Head Start-Start Collaboration
Project
124 State Capitol Building
Denver, CO 80203
(303) 866-4609
(303) 866-6368 Fax
lynn.johnson@state.co.us

Connecticut
Grace Caruso Whitney
Governor's Collaboration for Young
Children
Department of Social Services
Hartford, CT 06106
(860) 424-5066
(860) 951-2966 Fax
grace.whitney@po.state.ct.us

Head Start-State Collaboration Offices (Continued)

Delaware
Betty B. Richardson
State of Delaware Department of Education
Improvement and Assistance Branch
Townsend Building
P.O. Box 1402
Dover, DE 19903
(302) 739-4667, ext. 3131
(302) 739-2388 Fax
brichardson@state.de.us
Web site: www.dart.dps.state.de.us

District of Columbia
Beverly Roberson Jackson
D.C. Head Start-State Collaborative Office
717 Fourteenth Street, NW
Suite 730
Washington, DC 20005
(202) 727-1839
(202) 727-9709 Fax
brjackson1@juno.com

Florida
Katherine Kamiya
Florida's Collaboration for Young Children and Their Families
Head Start-State Collaboration Office
1310 Cross Creek Circle
Suite A
Tallahassee, FL 32301
(850) 487-0037
(850) 487-0045 Fax
kkamiya@com1.med.usf.edu

Georgia
Robert Lawrence
Georgia Head Start-State Collaboration Office
Georgia Office of School Readiness
10 Park Place South, Suite 200
Atlanta, GA 30303
(404) 656-5957
(404) 651-7184 Fax
lert@mail.osr.state.ga.us

Hawaii
Laverne Moore
Hawaii Department of Education
Community Education Center
Hawaii Head Start-State Collaboration Project
634 Pensacola
Rm. 99-A
Honolulu, HI 96819
(808) 594-0182
(808) 594-0181 Fax
lavernemoore@mailexcite.com

Idaho
Katherine Pavesic
Idaho Head Start Association, Inc.
200 North 4th Street
Suite 20
Boise, ID 83702
(208) 345-1182
(208) 345-1163 Fax
pavesic@rmci.net

Head Start-State Collaboration Offices (Continued)

Illinois
Gina Ruther
Illinois Department of Human Services
10 Collinsville Avenue
East St. Louis, IL 62201
(217) 785-2559
(271) 524-6029 Fax
dhsd60A2@dhs.state.il.us

Indiana
Donna Hogle
402 West Washington Street, Room W461
Indianapolis, IN 46204
(317) 233-6837
(317) 233-4693 Fax
dhogle@fssa.state.in.us
Web site: www.ai-org/fssa

Iowa
Anita Varme
Iowa Department of Education
Bureau of Children, Families, and
Community Services
Grimes State Office Building
Des Moines, IA 50319-0146
(515) 242-6024
(515) 242-6025 Fax
anita.varme@ed.state.ia.us

Kansas
Verna Weber (Acting)
Kansas Department of Social and
Rehabilitation Services
Docking State Office Building
915 Southwest Harrison, Room 681 South
Topeka, KS 66612
(785) 296-3349 or (785) 291-3314
(785) 296-0146 Fax
vsw@srskansas.org
Web site: www.ink.org/public/srs/

Kentucky
Kurt Walker
Kentucky Head Start-State Collaboration
Office
1715 Capital Plaza Tower
500 Mero Street
Frankfort, KY 40601
(502) 564-3010
(502) 564-6952 Fax
Fax/Data: (502) 564-2689
Web site: www.kih.net/kycollaboration

Louisiana
Shirley G. Will
LA/DSS/OFS/Head Start-State
Collaboration Unit
412 Fourth Street
Suite 101
Baton Rouge, LA 70802
(225) 219-4245
(225) 219-4248 Fax
swillia@dss.state.la.us

Maine
Dianne Stetson
Office of Child Care and Head Start
Department of Human Service
State House Station II
Augusta, ME 04333-0011
(207) 287-5060
(207) 287-5031 Fax
dianne.stetson@state.me.us

Head Start-State Collaboration Offices (Continued)

Maryland
Brenda Coakley Rouse
Governor's Office for Children, Youth and Families
301 West Preston Street
15th Floor
Baltimore, MD 21212
(410) 767-4196
(410) 333-5248 Fax
Brenda@mail.ocyf.state.md.us

Massachusetts
Dee Bertozz
Executive Office of Health and Human Services
One Ashburton Place, #1109
Boston, MA 02108
(617) 727-7600
(617) 727-1396 Fax
DBertozzi@state.ma.us
Web site: Magnet.State.Ma.us/eohhs/

Michigan
Sandy Little
Michigan Family Independence Agency
Head Start-State Collaboration Project
235 South Grand Avenue
Suite 1302
P.O. Box 30037
Lansing, MI 48909
(517) 335-3610
(517) 241-9033 Fax
littles@state.mi.us

Minnesota
Francie Mathes
Minnesota Department of Children, Families and Learning
MN Head Start-State Collaboration Office
1500 W Hwy 36
Roseville, MN 55113
(651) 582-8405
(651) 582-8491 Fax
Francie.Mathes@state.mn.us
Web site: www.des.state.mn.us

Mississippi
Vacant
Mississippi Head Start-State Collaboration Office
Office for Children and Youth
Mississippi Department of Human Service
750 North State Street
Jackson, MS 39202
(601) 359-4553
(601) 359-4422 Fax

Missouri
Chris Groccia, Director
3 Stanley Hall, University of Missouri
Columbia, MO 65211-6280
(573) 884-0579
(573) 884-0598 Fax
grocciac@missouri.edu

Montana
Mary Jane Standaert
Head Start-State Collaboration Office
P.O. Box 202952
Helena, MT 59604-2952
(406) 444-2547
(406) 443-6186 Fax
mstandaert@mt.gov

Head Start-State Collaboration Offices (Continued)

Nebraska
Eleanor Shirley-Kirkland
Nebraska Head Start-State Collaboration Office
Nebraska Department of Education
Office of Children and Families
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509-4987
(402) 471-3501
(402) 471-0117 Fax
kirkland@edneb.org
http://nde4.nde.state.ne.us/ECH/ECH.html

Nevada
Kellie Smith Bates
Nevada Head Start-State Collaboration Office
Early Intervention Services/State of Nevada-DHS
3987 South McCarran Boulevard
Reno, NV 89502
(702) 668-2284
(702) 588-2558
Faxkbates@govmail.state.nv.us

New Hampshire
Ann B. Ringling
New Hampshire Department of Health and Human Services
NH Head Start-State Collaboration Office
Child Development Bureau
129 Pleasant Street
Concord, NH 03301-6505
(603) 271-4454
(603) 271-7982 Fax
ringlin@dhhs.state.nh.us

New Jersey
Teresa Buccarelli
Head Start-State Collaboration Office
DHS Office of Early Care and Education
P.O. Box 700
Trenton, NJ 8625-0700
(609) 633-5321
(609) 292-1903 Fax
Tbuccarel@dhs.state.nj.us

New Mexico
Barbara A. Loveless
Department of Children, Youth and Families
P.O. Drawer 5160, Room 111
Sante Fe, NM 87502-5160
(505) 827-9952
(505) 827-7361 Fax

New York
Judith Sikora, Director
New York State Council on Children & Families
5 Empire State Plaza, Suite 2810
Albany, NY 12223-1553
(518) 474-6294
(518) 473-2570 Fax
Judys@capital.net

North Carolina
Ronald Moore
North Carolina Head Start-State Collaboration Office
Division of Child Development
P.O. Box 29553
319 Chapanoke Road
Raleigh, NC 27626-0553
(919) 662-4543
(919) 662-4568 Fax
Ronald.Moore@ncmail.net

Head Start-State Collaboration Offices (Continued)

North Dakota
Jody Netzer
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505
(701) 328-3538
(701) 328-2359 Fax
sonetj@state.nd.us

Ohio
Terrie Hare
Project Director
OFCF, Head Start Ohio Collaboration Office
Office of the Governor
77 South High Street, 30th Floor
Columbus, OH 43266-0601
(614) 728-9435
(614) 728-9441 Fax
haret@odhs.state.oh.us

Barbara Haxton
Co-Director, OSCO, and
Executive Director, Ohio Head Start Association
505 Windsor Park Drive
Dayton, OH 45459
(937) 435-1113
(937) 435-5411 Fax
haxton@erinet.com

Oklahoma
Leslie A. Porter
OACAA
2915 Classen, Suite 215
Oklahoma City, OK 73106
(405) 524-4124
(405) 524-0863 Fax
Lporter530@aol.com

Oregon
Dell Ford, Director
Oregon Department of Education
Public Service Building
255 Capitol Street, NE
Salem, OR 97310-0203
(503) 378-5585, ext 662
(503) 373-7968 Fax
dell.ford@state.or.us

Pennsylvania
Sharon L. Brumbaugh
Head Start-State Collaboration Office
Center for Schools and Communities
1300 Market Street, Suite 12
Lemoyne, PA 17043
(717) 763-1661
(717) 763-2083 Fax
sbrumbau@northstar.csiu-pa.us

Puerto Rico
Mary Josephine Doran Gelabert
Executive Director
Puerto Rico Head Start-State Collaboration Office
Governor's Office
La Fortaleza, P.O. Box 902-0082
San Juan, PR 00902-0082
(787) 721-7000, ext. 2614 or 2615
(787) 721-5336 Fax

Rhode Island
Larry Pucciarelli
Department of Human Services
Louis Pasteur Building
#57 Howard Avenue
Cranston, RI 02920
(401) 462-3071
(401) 462-1846 Fax
lpucciar@gw.dhs.state.ri.us

Head Start-State Collaboration Offices (Continued)

South Carolina
Mary Lynne Diggs
South Carolina Head Start-State
Collaboration Office
South Carolina Department of Health and
Human Services
1801 Main Street
10th Floor
Columbia, SC 29201
(803) 898-2861
(803) 253-4513 Fax
Diggs@dhhs.state.sc.us

South Dakota
Betsy Pollock
South Dakota Department of Education
and Cultural Affairs (DECA)
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-4640
(605) 773-6846 Fax
betsy.pollock@state.sd.us
Web site: http://www.state.sd.us
(click on DECA Comprehensive Services
or Early Childhood Services)

Tennessee
James Jackson (Interim)
Tennessee Department of Education
Office of School-Based Support Services
Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243-0375
(615) 532-4981
(615) 532-4889 Fax
jjackson@mail.state.tn.us

Texas
Gwen D. Chance, Director
Charles A. Dana Center
University of Texas at Austin
2901 North I.H.-35
Room 2.200
Austin, TX 78722-2348
(512) 232-2258
(512) 232-1853 Fax
gwen_c@mail.utexas.edu

Utah
Janna Forsgren
Utah Department of Health
Child, Adolescent & School Health
Programs (CASH)
P.O. Box 142001
Salt Lake City, UT 84114-2001
(801) 538-9312
(801) 538-9409 Fax
jforsgre@doh.state.ut.us

Vermont
K.C. Whiteley
Agency of Human Services
103 South Main Street
Waterbury, VT 05671-0204
(802) 241-2705
(802) 241-2979 Fax
kcw@wpgate1.ahs.state.vt.us

Virginia
Francine Bryce
Child Day Care Programs
Department of Social Services
730 East Broad Street, 2nd Floor
Richmond, VA 23219-1849
(804) 692-0935
(804) 786-9610 Fax
Fgb2@e-mail1.dss.state.va.us

Head Start-State Collaboration Offices (Continued)

Washington
Terry Liddell
Governor's Head Start-State
Collaboration Project
P.O. Box 45015
Olympia, WA 98504-5015
(360) 407-0806
(360) 407-0808 Fax
Liddetn@dshs.wa.gov

West Virginia
William Huebner
Governor's Cabinet on Children and
Families
1900 Kanawha Boulevard East
Building 5, Room 218
Charleston, WV 25305
(304) 558-4638
(304) 558-0596 Fax
bhuebner@wvnvm.wvnet.edu

Wisconsin
Julia Herwig
Office of Child Care Wisconsin
Department of Workforce Development
201 E. Washington Avenue
Madison, WI 53707-7935
(608) 261-4596
(608) 267-3240 Fax
jh720@aol.com

Wyoming
Terri Longhurst
Head Start-State Collaboration Office
1465 N. 4th Street
Laramie, WY 82072
(307) 766-2452
(307) 766-2763 Fax
lnghurst@uwyo.edu

Appendix 5

Regional and Agency Contacts

Highlights

A. Regional Contacts

B. National and Agency Web Sites

C. Other Sources of Information

BEST COPY AVAILABLE

A. Regional Contacts

For each of the ten federal regions, the office address is listed followed by contacts in the following order:

- Administration for Children and Families (ACF)
  Assistant Regional Administrator
- ACF Regional Child Care Liaison
  Associate Regional Administrator
- Health Care Financing Administration (HCFA)
  Associate Regional Administrator
- Medicaid's MCH/EPSDT Regional Coordinator
- Public Health Service (PHS)
  Regional Maternal and Child Health (MCH) Program Consultant

The Head Start Bureau has two additional Regions, XI and XII, which are listed below the ten federal regions.

***Region I:* Connecticut, Maine, Massachusetts, Rhode Island, Vermont**

Regional Office: JFK Federal Building
Government Center
Boston, MA 02203-0003

ACF Assistant Regional Administrator
Office of Family Supportive Services
Room 2000
(617) 565-1150
(617 565-2493 Fax

ACF Child Care Liaison
Program Specialist, Child Care Unit
Room 2025
617-565-1150
617-565-2493 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
Room 2350
(617) 565-1223
(617) 565-1083 Fax

HCFA MCH/EPSDT Coordinator
(617) 565-1248
(617) 565-1083 Fax

PHS MCH Program Consultant, Room 1826
(617) 565-1433
(617) 565-3044 Fax

***Region II:* New Jersey, New York, Puerto Rico, Virgin Islands**

Regional Office: Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

ACF Assistant Regional Administrator
Office of Family Support Services
Room 4114
(212) 264-2892
(212) 264-4826 Fax

ACF Child Care Liaison
Room 4114
212-264-2890 ext. 138
212-264-4881 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
Room 3811
(212) 264-4488
(212) 264-2580 Fax

HCFA MCH/EPSDT Coordinator
(212) 264-3841
(212) 264-2790 Fax

PHS MCH Program Consultant
Room 3835
(212) 264-2571
(212) 264-2673 Fax

***Region III:* Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia**

Regional Office: The Public Ledger
Building
150 S. Independence Mall West
Philadelphia, PA 19106

ACF Regional Administrator
(215) 861-4099
(215) 861-4071 Fax

ACF TANF/Child Care Program Manager
Suite 864
215-861-4058
215-861-4070

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
Suite 216
(215) 861-4263
(215) 861-4240 Fax

HCFA MCH/EPSDT Coordinator
(215) 861-4252
(215) 861-4240 Fax

PHS MCH Program Consultant
3535 Market Street, Room 10140
Philadelphia, PA 19104
(215) 596-6686
(215) 596-4137 Fax

***Region IV:* Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee**

Regional Office: Atlanta Federal Center
Suite. 5B95
61 Forsyth Street, SW, 4T20
Atlanta, GA 30303-8909

ACF HUB Director
(404) 562-2800
(404) 562-2983 Fax

ACF Child Care Liaison
Suite 4M60
(404) 562-2892
(404) 562-2985

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
(404) 562-7359
(404) 562-7483 Fax

HCFA MCH/EPSDT Coordinator
(404) 562-7410
(404) 562-7483 Fax

PHS, MCH Program Consultant
101 Marietta Tower, N.E., Suite 1202
Atlanta, GA 30323
(404) 331-5394
(404) 730-2983 Fax

Region V: **Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin**

Regional Office: 105 West Adams Street
Chicago, IL 60603-6201

ACF Assistant Regional Administrator
(312) 353-4439
(312) 353-2204 Fax

ACF Child Care Liaison
20th Floor
(312) 353-5706
(312) 353-2204 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
(312) 353-9805
(312) 353-3419 Fax

HCFA MCH/EPSDT Coordinator
(312) 353-8720 or (312) 353-3721
(312) 353-5927 Fax

PHS MCH Program Consultant
(312) 353-4042
(312) 886-3770 Fax

Region VI: **Arkansas, Louisiana, New Mexico, Oklahoma, Texas**

Regional Office: 1200 Main Tower
Building, Suite 1100
Dallas, TX 75202

ACF Assistant Regional Administrator
State Programs
Office of Family Support Services
(214) 767-9648
(214) 767-3743 Fax

ACF Child Care Liaison
1301 Young Street, Room 945 (ACF-2)
Dallas, TX 75202
(214) 767-3849
(214) 767-8890 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
1301 Young Street, Suite 833
Dallas, TX 75202
(214) 767-6301
(214) 767-0630 Fax

HCFA MCH/EPSDT Coordinator
(214) 767-6497
(214) 767-6400 Fax

PHS MCH Program Consultant
MCH/Family Planning Branch
1301 Young Street, 10th Floor, HRSA-4
Dallas, TX 75202
(214) 767-3003
(214) 767- 8049 Fax

Region VII: **Iowa, Kansas, Missouri, Nebraska**

Regional Office: Richard Bolling
Federal Building
601 East 12th Street, Room 210
Kansas City, MO 64106-2808

ACF Regional Administrator
(816) 426-3981
(816) 426-2888 Fax

ACF Child Care Liaison
Room 276
(816) 426-5211 ext. 193
(816) 426-2888 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
Room 227
(816) 426-5925, ext. 3301
(816) 426-3851 Fax

HCFA MCH/EPSDT Coordinator
(816) 426-3406
(816) 426-3851 Fax

PHS MCH Program Consultant
(816) 426-5292
(816) 426-3633 Fax

Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Regional Office: Federal Office Building
1961 Stout Street
Denver, CO 80294-3538

ACF Regional Administrator
Room 924
(303) 844-3100, ext. 301
(303) 844-3642 Fax

ACF Child Care Liaison
Room 924
(303) 844-3100, ext. 374
(303) 844-3642 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
Room 522
(303) 844-4024, ext. 426
(303) 844-3753 Fax

HCFA MCH/EPSDT Coordinator
(303) 844-4024 or (303) 844-2121, ext. 454
(303) 844-3753 Fax

PHS MCH Program Consultant
(303) 844-3204, Ext. 217
(303) 844-0002 Fax

Region IX: American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Marianas Islands

Regional Office: Federal Office Building
50 United Nations Plaza
San Francisco, CA 94012

ACF HUB Director
Office of Family Support Services
(415) 427-8400
(415) 437-8438 Fax

ACF Child Care Liaison
Room 351
(415) 437-8439
(415) 437-8436 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
75 Hawthorne Street
4th and 5th Floors
San Francisco, CA 94105-3903
(415) 744-3571
(415) 744-2933 Fax

HCFA MCH/EPSDT Coordinator
(415) 744-3579
(415) 744-2933 Fax

PHS MCH Program Consultant
Room 317
(415) 437-8101
(415) 437-8105 Fax

***Region X:* Alaska, Idaho, Oregon, Washington**

Regional Office: 2201 Sixth Avenue
Blanchard Plaza Building
Seattle, WA 98121-2500

ACF Regional Administrator
(206) 615- 2547, ext. 2249
(206) 615-2575 Fax

ACF Child Care Liaison
Suite 600
(206) 615-2558, ext. 3083
(206) 615-2575 Fax

HCFA Associate Regional Administrator
Division of Medicaid & State Operations
(206) 615-2334 (206) 615-2435 Fax

HCFA MCH/EPSDT Coordinator
(206) 615-2400
(206) 615-2435 Fax

PHS MCH Program Consultant
(206) 615-2518
(206) 615-2500 Fax
Mail Stop RX-27

Head Start Bureau
Region XI

American Indian Programs Branch
330 C Street, SW
Washington, DC 20447
(202) 205-8437
(202) 205-8436 Fax

Head Start Bureau
Region XII

Migrant Programs Branch
330 C Street, SW
Washington, DC 20447
(202) 401-2121
(202) 401-5916 Fax

B. National and Agency Web Sites

Federal Web Sites at the National Level

Contact these sites for information about Medicaid and CHIP, model child health programs, health outreach programs, and partnerships, and to obtain other related information.

U.S. Department of Health and Human Services

Heath Care Financing Administration (HCFA)
http://www.hcfa.gov/init/children.htm

Health Resources & Services Administration (HRSA)
http://www.bphc.hrsa.gov
http://www.hrsa.dhhs.gov/childhealth

Maternal and Child Health Bureau
http://www.mchb.hrsa.gov/index.html

Child Care Bureau
http://www.acf.dhhs.gov/programs/ccb/

For state child care contacts access:
http://nccic.org/dirs/devfund.html

Head Start Bureau
http://www.acf.dhhs.gov/programs.hsb

Federally Sponsored Web site

This Web site is sponsored by the White House, the National Governors' Association, and the Department of Health and Human Services. It offers links to state Web sites as well.

Insure Kids Now
http://www.insurekidsnow.gov/
National toll free number: 1-877-Kids-Now

C. Other Sources of Information

Contact these Web sites to learn more about partnership strategies, state efforts, advocacy, outreach, research, and private funding to support health education. Some organizations offer free outreach materials, fact sheets, and brochures about CHIP.

American Academy of Pediatrics
http://www.aap.org
(847) 228-5005

American School Health Association
http://www.ashaweb.org
(330) 678-1601

Association of Maternal and Child Health Programs
http://www.amchp1.org
(202) 775-0436

Center for Health Care Strategies
http://www.chcs.org
(609) 279-0700

Center on Budget and Policy Priorities
http://wwwcbpp.org
(202) 408-1080

Center for Health Policy Research
http://www.gwumc.edu/chpr
(202) 296-6922

Center for School Mental Health Assistance
http://csmha.ab.umd.edu
1 (888) 706-0980

Children's Defense Fund
http://www.childrensdefense.org
(202) 628-8787

Child Welfare League of America
http://www.cwla.org
(202) 638-2952

Families USA
http://www.familiesusa.org
(202) 628-3030

Family Voices
http://www.familyvoices.org/~vrosales/
(505) 867-2368

National Academy of State Health Policy
http://www.hashp.org
(207) 874-6524

National Association of Child Advocates
http://www.childadvocacy.org
(202) 289-0777

National Center for Education in Maternal and Child Health
http://www.ncemch.org
(703) 524-7802

National Center for Farm Workers Health
http://www.ncfh.org
(512) 312-2700

National Coalition for the Homeless
http://nch.ari.net/
(202) 737-6444

National Conference of State Legislatures
http://www.stateservhpts.org
(303) 830-2200

National Council of La Raza
http://www.nclr.org
(202) 785-1670

National Education Association Health Information Network
http://www.nea.org
(202) 833-4000

National Governors' Association
http://www.nga.org
(202) 624-5330

National Healthy Mothers Healthy Babies Coalition
http://www.childrenshealthfund.org
(703) 836-6110

National Health Law Program
http://www.healthlaw.org
(202) 289-7661

National Health Policy Forum
http://www.nhpf.org
(202) 872-1390

National Mental Health Association
http://www.nmha.org
(703) 684-7722

National Rural Health Association
http://www.nrharural.org
(803) 771-2810

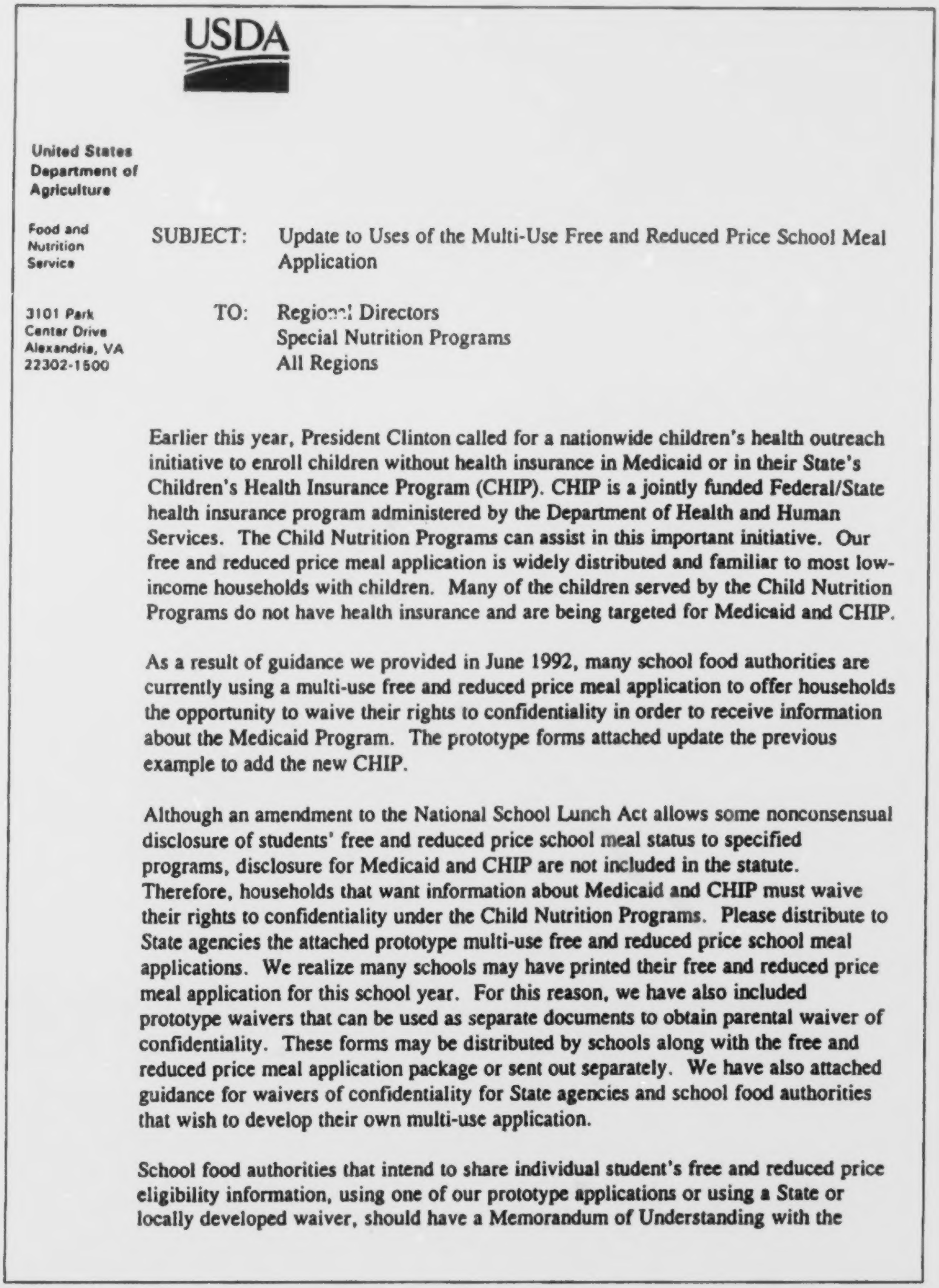
Robert Wood Johnson Foundation
http://www.rwjf.org
(609) 452-8701

Southern Institute on Children & Families
http://www.kidsouth.org
and
http://www.coveringkids.org
(803) 779-2607

The Arc of the United States
http://TheArc.org/welcome.html
(817) 261-6003

Appendix 6

Confidentiality Waiver Examples



USDA

United States
Department of
Agriculture

Food and
Nutrition
Service

3101 Park
Center Drive
Alexandria, VA
22302-1500

SUBJECT: Update to Uses of the Multi-Use Free and Reduced Price School Meal Application

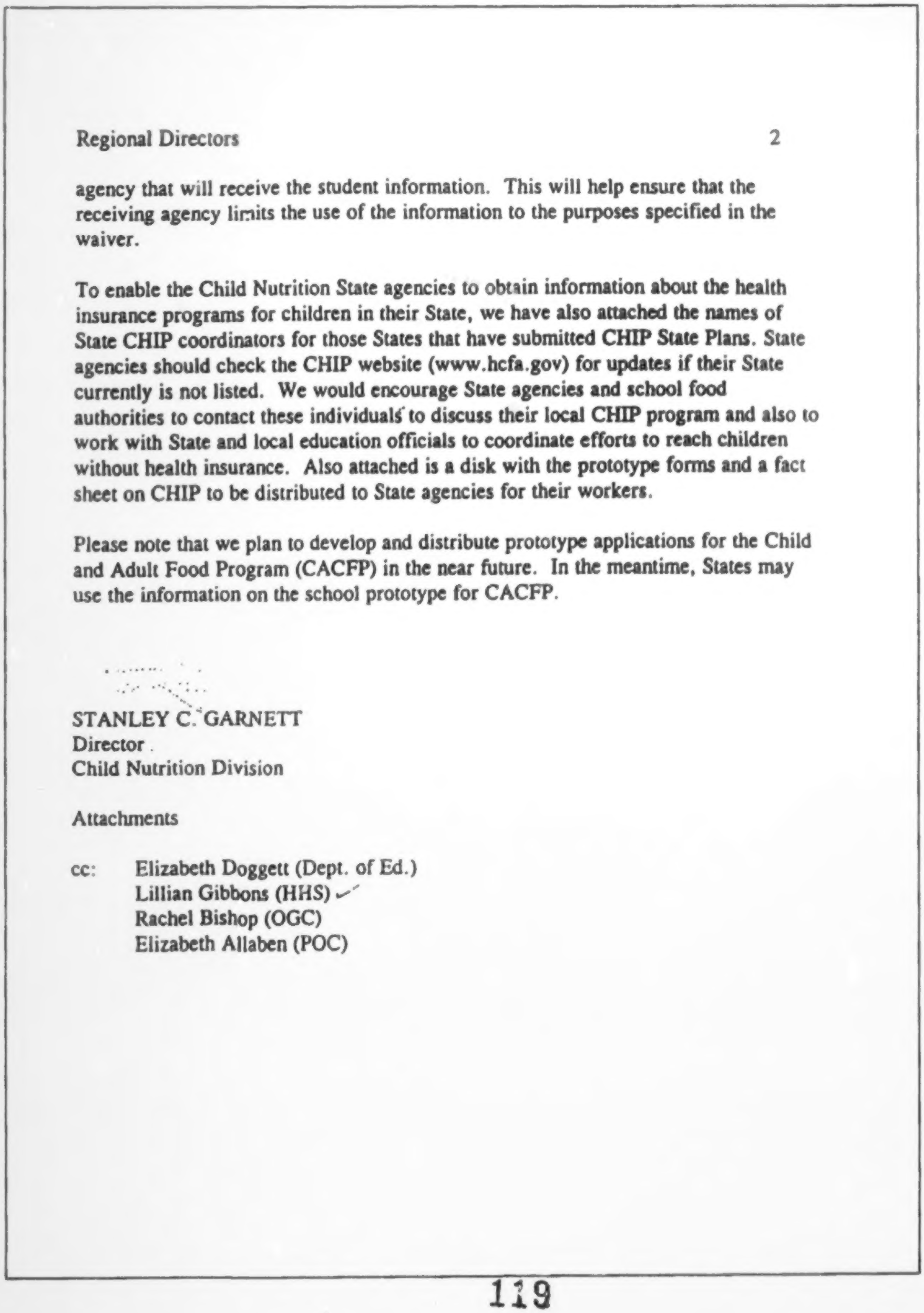
TO: Regional Directors
Special Nutrition Programs
All Regions

Earlier this year, President Clinton called for a nationwide children's health outreach initiative to enroll children without health insurance in Medicaid or in their State's Children's Health Insurance Program (CHIP). CHIP is a jointly funded Federal/State health insurance program administered by the Department of Health and Human Services. The Child Nutrition Programs can assist in this important initiative. Our free and reduced price meal application is widely distributed and familiar to most low-income households with children. Many of the children served by the Child Nutrition Programs do not have health insurance and are being targeted for Medicaid and CHIP.

As a result of guidance we provided in June 1992, many school food authorities are currently using a multi-use free and reduced price meal application to offer households the opportunity to waive their rights to confidentiality in order to receive information about the Medicaid Program. The prototype forms attached update the previous example to add the new CHIP.

Although an amendment to the National School Lunch Act allows some nonconsensual disclosure of students' free and reduced price school meal status to specified programs, disclosure for Medicaid and CHIP are not included in the statute. Therefore, households that want information about Medicaid and CHIP must waive their rights to confidentiality under the Child Nutrition Programs. Please distribute to State agencies the attached prototype multi-use free and reduced price school meal applications. We realize many schools may have printed their free and reduced price meal application for this school year. For this reason, we have also included prototype waivers that can be used as separate documents to obtain parental waiver of confidentiality. These forms may be distributed by schools along with the free and reduced price meal application package or sent out separately. We have also attached guidance for waivers of confidentiality for State agencies and school food authorities that wish to develop their own multi-use application.

School food authorities that intend to share individual student's free and reduced price eligibility information, using one of our prototype applications or using a State or locally developed waiver, should have a Memorandum of Understanding with the



agency that will receive the student information. This will help ensure that the receiving agency limits the use of the information to the purposes specified in the waiver.

To enable the Child Nutrition State agencies to obtain information about the health insurance programs for children in their State, we have also attached the names of State CHIP coordinators for those States that have submitted CHIP State Plans. State agencies should check the CHIP website (www.hcfa.gov) for updates if their State currently is not listed. We would encourage State agencies and school food authorities to contact these individuals to discuss their local CHIP program and also to work with State and local education officials to coordinate efforts to reach children without health insurance. Also attached is a disk with the prototype forms and a fact sheet on CHIP to be distributed to State agencies for their workers.

Please note that we plan to develop and distribute prototype applications for the Child and Adult Food Program (CACFP) in the near future. In the meantime, States may use the information on the school prototype for CACFP.

STANLEY C. GARNETT
Director
Child Nutrition Division

Attachments

cc: Elizabeth Doggett (Dept. of Ed.)
Lillian Gibbons (HHS)
Rachel Bishop (OGC)
Elizabeth Allaben (POC)

MULTI-USE FREE AND REDUCED PRICE MEAL APPLICATION

Interested State agencies and school food authorities should contact their State Children's Health Insurance Program (CHIP) coordinator to discuss use of the free and reduced price meal application to outreach to low-income children who may not have health insurance. USDA developed two prototype free and reduced price meal applications that may be used for this purpose. Although the two applications look similar, they are different in the information that may be released with parental/guardian consent. Two additional prototype forms were developed that may be distributed to households separately from the free and reduced price application. These forms are intended for schools that have already printed their free and reduced price meal application or who do not want to use a multi-use free and reduced price meal application, but want to participate in Medicaid and CHIP outreach. These may be distributed with the application package or separately anytime during the school year. Your State or local CHIP coordinator can tell you which of the prototype forms would be best for outreaching and enrolling children in CHIP. State agencies and school food authorities may also develop their own forms which may better suit State and local needs.

VERSION 1

This prototype free and reduced price meal application allows households to permit school food service personnel to give all information contained on the free and reduced price meal application to Medicaid and CHIP officials. This would include the child's name, names of all household members, all income information or a program case number (food stamp, Temporary Assistance for Needy Families, Food Distribution Program on Indian Reservations) address, social security number of the adult household member. A photocopy of the application provided to Medicaid/CHIP officials would also be permitted under this option. If the adult's social security number is disclosed, the privacy act statement must be changed to advise parents of this and the intended uses of the number.

VERSION 2

This prototype free and reduced price meal application allows households to permit school food service personnel to give only their name and address, and an indication that the household had applied for free and reduced price meals, to Medicaid and CHIP officials to facilitate outreach to these families.

VERSION 3

This prototype form may be distributed separately from the free and reduced price application. However, the form may be attached to the free and reduced price meal application and sent out at the same time or distributed separately from the free and

GUIDANCE FOR WAIVER OF CONFIDENTIALITY

Any State agency or school food authority wishing to develop their own waiver of confidentiality statement to allow households to waive their rights to confidentiality under the Child Nutrition Programs must adhere to the following guidelines:

1. The waiver must advise the household that the information provided on the free and reduced price meal application will be used for other programs.

2. The waiver must precisely identify the agencies the information will be shared with and for what purposes.

3. The application must state that the signing of the waiver must not be construed by the applicant or the program administrator as an additional requirement or a prerequisite for participation in any of the child nutrition programs.

4. The applicant must be able to limit the waiver to encompass only those programs to which he or she wishes to share information. For example, the waiver could use a check-off system under which the applicant would check or initial a box to indicate that he or she wants to apply for benefits from a particular program.

5. Although the application for school meals or milk may be signed by any adult household member, the waiver of confidentiality must be signed by the parent or legal guardian for the child.

6. When using a multi-use application and disclosing the social security number provided by the household on the application, the notice required by the Privacy Act of 1974 must be modified. The notice must inform households that the social security number may be used by the other programs and for what purpose. For example, if Medicaid officials plan to match the household member's name and social security number against the list of Medicaid participants, the privacy act statement on the free and reduced price application must be modified to inform the household of this fact and the reason for the match, such as to determine whether the household is currently receiving Medicaid benefits.

7. The State agency or school food authority must ensure, in writing, that entities receiving children's free and reduced price eligibility information limit the use of such information to the purposes specified in the waiver request. This may be done through, a Memorandum of Understanding with the agency or agencies who will receive the information. This is to ensure that the household's rights to privacy are respected by using the information only for the purposes agreed to.

PROTOTYPE LETTER TO HOUSEHOLDS
SCHOOL NUTRITION PROGRAMS

Dear Parent/Guardian:

The ____________________ School offers a choice of healthy meals each school day. Children may buy lunch for ___________ and breakfast for ___________. Children who qualify under U.S. Department of Agriculture guidelines *may get meals free or at a reduced price of* ___________ *for lunch and* ___________ for breakfast. All meals served must meet nutrition standards established by the U.S. Department of Agriculture. If a child has a disability, as determined by a doctor, and the disability prevents the child from eating the regular school meal, the school will make substitutions prescribed by the doctor. If a substitution is needed, there will be no extra charge for the meal. Please call the school for further information.

Income Chart For School Year 1998-99			
Household size	**Yearly**	**Monthly**	**Weekly**
1	14,893	1,242	287
2	20,073	1,673	387
3	25,253	2,105	486
4	30,433	2,537	586
5	35,613	2,968	685
6	40,793	3,400	785
7	45,973	3,832	885
8	51,153	4,263	984
For each additional household member add	+5,180	+432	+100

Your child can get free school meals if you get food stamps, Temporary Assistance for Needy Families (TANF) or benefits from the Food Distribution Program on Indian Reservation (FDPIR). If your total household income is the same or below the amount on the Income Chart, your child can get either free meals or reduced price.

How do I get free or reduced price school meals for my child? You must complete the free and reduced price school meal application and return it to the school.

- ***Households getting food stamps, TANF, or benefits from FDPIR.*** You only have to include your child's name, case number and an adult household member must sign the application.
- Other ***households***. If you do not have a case number, you have to include the names of all household members, the amount of income each person got last month and where the income came from. An adult household member must sign the application and include his or her social security number.
- ***Households with a foster child.*** You must include the child's name, the amount of "personal use "income the child got last month and an adult must sign the application

Will the application be verified? Your eligibility may be checked at anytime during the school year. School officials may ask you to send papers that show that your child should get free or reduced price school meals. **Can I appeal the school's decision?** You can talk to school officials if you do not agree with the school's decision on your application or the results of verification. You also may ask for a fair hearing by calling or writing: ______________________________ Phone ______________

Address ____

Can I get other benefits, such as health insurance, for my child? Your child may be eligible for a new ***health insurance program for children***. Please look at Part 6 on the free and reduced price school meal application if you do not have health insurance for your child.
Must I report changes? If your child gets free or reduced price meals because of your income, you must tell us if your household size decreases or your income increases by more than $50 per month or $600 per year. If your child get free meals because he or she gets food stamps, TANF or benefits from FDPIR, you must tell us when you no longer get these benefits.
Will information on my application be kept confidential? We will use the information on your application to decide if your child should get free or reduced price meals. We may inform officials connected with Title I and the National Assessment of Educational Progress whether your child is eligible for free or reduced price school meals. They will use this information for funding and/or evaluation purposes. Information may also be disclosed if you want the application to be used to get other benefits. See Part 6 on the application.
Can I apply for free and reduced price meals later? You may apply for free and reduced price meals anytime during the school year. If you are not eligible now but have a change, like a decrease in household income, an increase in household size, become unemployed or get food stamps or TANF or benefits from FDPIR, complete an application then.

We will let you know if you are approved or denied.

Sincerely,

HOW TO COMPLETE THE FREE AND REDUCED PRICE SCHOOL MEAL APPLICATION

lease complete the Free and Reduced Price School Meal Application using the instructions below. Sign the application and return it the school. Call the school if you need help: #____________________

STUDENT INFORMATION: Print your child's name.

ARE YOU APPLYING FOR A FOSTER CHILD? Complete this Part and sign the application in #5.

a) Write the foster child's monthly "personal use" income. Write "0" if the foster child does not get "personal use" income.

b) A foster parent or other official representing the child must sign the application in #5. You do not have to list a social security number.

DO YOU GET FOOD STAMPS or BENEFITS FROM THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR) or TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) ?

Complete this Part and sign the application in #5.

a) List your current food stamp case number or your FDPIR or TANF case number for the child.

b) Sign the application in #5. An adult household member must sign. You do not have to list a social security number.

ALL OTHER HOUSEHOLDS: Complete this Part and sign the application in #5.

a) Write the names of everyone in your household even if they do not have an income. Include yourself, the child you are applying for and all other children.

b) Write the amount of income each person received last month before taxes or anything else was taken out; and where it came from, such as earnings, welfare, pensions, and other income (see the examples below for types of income to report). If any amount last month was more or less than usual, write that person's usual monthly income.

c) Sign the application and include a social security number in #5.

SIGNATURE AND SOCIAL SECURITY NUMBER:

a) The application must have the signature of an adult household member.

b) The adult household member who signs the statement must include his/her social security number. *If he/she does not have a social security number, write "none" or something else to show that he/she does not have a social security number.* A social security number is not needed if you listed a food stamp, FDPIR or TANF case number or if you are applying for a foster child.

OTHER BENEFITS:. You may be eligible for free or low-cost health insurance for your child. Look at Part 6 on the back of the application for free and reduced price school meals. You are not required to complete this to get meal benefits

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RACIAL/ETHNIC IDENTITY: You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.

INCOME TO REPORT

arnings from Employment
ages/salaries/tips
trike benefits
nemployment compensation
orker's compensation
et income from self-owned business or farm

elfare/Child Support/Alimony
ublic assistance payments
elfare payments
limony/child support payments

Pensions/Retirement/Social Security
Pensions
Supplemental Security Income
Retirement income
Veteran's payments
Social security

Other Income/Self-employment
Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/ investments
Regular contributions from persons not living in the household
Net royalties/annuities/ net rental income
Any other income

Version 1

FREE AND REDUCED PRICE SCHOOL MEAL APPLICATION

Complete, sign and return the application to the school. Please read the instructions. Call the school if you need help completing this form.

1 CHILD'S NAME:

________________________________ **Grade:** ______ **Room:** ____________
Last **First** **M.I.**

2 Is this a FOSTER CHILD? (See the instructions) If this is a foster child, check here [ ] and write the child's monthly income here: $________________. Go to section #5.

3 Are you getting FOOD STAMPS, TANF or FDPIR benefits for your child? List the case number. DO NOT Complete section #4. Go to section #5.

Food stamp case number:______________________ **FDPIR case number:**______________________

TANF case number:______________________

4 ALL OTHER HOUSEHOLDS: (Complete this part only if you did not complete sections #2 or #3) List all household members, including the child listed above. List all income. Go to section #5.

Names	Current Monthly Income			
Names of Household Members (include the child named above)	Monthly Earnings from Work (Before Deductions) Job 1	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Monthly Earnings from Job 2 or any Other Monthly Income
1.__________	$__________	$__________	$__________	$__________
2.__________	$__________	$__________	$__________	$__________
3.__________	$__________	$__________	$__________	$__________
4.__________	$__________	$__________	$__________	$__________
5.__________	$__________	$__________	$__________	$__________
6.__________	$__________	$__________	$__________	$__________
7.__________	$__________	$__________	$__________	$__________
8.__________	$__________	$__________	$__________	$__________

5 SIGNATURE: An adult household member must sign the application before it can be approved.

PENALTIES FOR MISREPRESENTATION: *I certify that all of the above information is true and correct and that the food stamp, FDPIR, or TANF number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.*

Signature of Adult:______________________**Social Security Number:** __ __ __ - __ __ - __ __ __ __

Printed Name:______________________**Home Phone:**____________ **Work Phone:**____________

Home Address **Zip Code** **Date**

Privacy Act Statement. Unless you list the child's food stamp, FDPIR, or TANF case number, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the application or indicate that the household member does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the application does not have a social security number, we cannot approve the application. The social security number may be used to identify the household member in verifying the correctness of information stated on the application. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR, or TANF office to determine current certification for food stamps, FDPIR, or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

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6 OTHER BENEFITS - You do not have to complete this part to get free or reduced price school meals.

Health Insurance ☐ Yes. I want health insurance for my child. School officials may give information from my free and reduced price school meal application to Medicaid or Children's Health Insurance Program (CHIP) officials. Medicaid and CHIP officials may use the information to help determine whether my child is eligible for either Medicaid or CHIP. Medicaid and CHIP officials may contact me for more information.

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child. I give up my rights to confidentiality for this purpose only.

I certify that I am the parent/guardian of the child for whom application is being made.

Signature of parent/guardian________ ______________________________________ Date____________

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7 RACIAL/ETHNIC IDENTITY: You are not required to answer this question.

[ ] White, not of Hispanic Origin [ ] Black, not of Hispanic Origin [ ] Hispanic [ ] Asian or Pacific Islander [ ] American Indian or Alaska Native

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For School Use Only: Food stamp/FDPIR/TANF household categorically eligible free: [ ] Yes [ ] No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2

Total monthly income: ___________ Household size: __________ Eligible:________ NOT Eligible:_______

Determining official:__________________________ Signature: ______________________ Date: ___________

In the operation of the child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age or disability. If you believe that you or anyone has been discriminated against because of race, color, national origin, sex, age, or disability, write immediately to: Administrator, Food and Nutrition Service, U.S. Department of Agriculture, 3101 Park Center Drive, Alexandria, VA 22302.

FREE AND REDUCED PRICE SCHOOL MEAL APPLICATION

Complete, sign and return the application to the school. Please read the instructions. Call the school if you need help completing this form.

1 CHILD'S NAME:

______________________ ______________________ ______________ **Grade:** ______ **Room:** ____________

Last **First** **M.I.**

2 Is this a FOSTER CHILD? (See the instructions) If this is a foster child, check here [ ] and write the child's monthly income here: $________________. Go to section #5.

3 Are you getting FOOD STAMPS, TANF or FDPIR benefits for your child? List the case number. DO NOT Complete Section #4. Go to section #5.

Food stamp case number:______________________ **FDPIR case number:**______________________________

TANF case number:______________________________

4 ALL OTHER HOUSEHOLDS: (Complete this part only if you did not complete sections #2 or #3) List all household members, including the child listed above. List all income. Go to section #5.

Names	Current Monthly Income			
Names of Household Members (include the child named above)	Monthly Earnings from Work (Before Deductions) Job 1	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Monthly Earnings from Job 2 or any Other Monthly Income
1.______________	$______________	$______________	$______________	$______________
2.______________	$______________	$______________	$______________	$______________
3.______________	$______________	$______________	$______________	$______________
4.______________	$______________	$______________	$______________	$______________
5.______________	$______________	$______________	$______________	$______________
6.______________	$______________	$______________	$______________	$______________
7.______________	$______________	$______________	$______________	$______________
8.______________	$______________	$______________	$______________	$______________

5 SIGNATURE: An adult household member must sign the application before it can be approved.

PENALTIES FOR MISREPRESENTATION: *I certify that all of the above information is true and correct and that the food stamp, FDPIR, or TANF number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.*

Signature of Adult:______________________________ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Printed Name:______________________________ **Home Phone:**______________ **Work Phone:**______________

____

Home Address **Zip Code** **Date**

Privacy Act Statement. Unless you list the child's food stamp, FDPIR, or TANF case number, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the application or indicate that the household member does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the application does not have a social security number, we cannot approve the application. The social security number may be used to identify the household member in verifying the correctness of information stated on the application. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR, or TANF office to determine current certification for food stamps, FDPIR, or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

6 OTHER BENEFITS - You do not have to complete this part to get free or reduced price school meals.

Health Insurance ☐ Yes. I want health insurance for my child. School officials may give my name and address to Medicaid or the Children's Health Insurance Program officials so that they can send me information about free or low-cost health insurance for my child.

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child. I give up my rights to confidentiality for this purpose only.

I certify that I am the parent/guardian of the child for whom application is being made.

Signature of parent/guardian____ **Date**__________

7 RACIAL/ETHNIC IDENTITY: You are not required to answer this question.

[ ] White, not of Hispanic Origin [ ] Black, not of Hispanic Origin [ ] Hispanic [ ] Asian or Pacific Islander [ ] American Indian or Alaska Native

For School Use Only: Food stamp/FDPIR/TANF household categorically eligible free: [ ] Yes [ ] No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2

Total monthly income: __________ Household size: __________ Eligible:________ NOT Eligible:______

Determining official:____________________ Signature: ____________________ Date: __________

In the operation of the child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age or disability. If you believe that you or anyone has been discriminated against because of race, color, national origin, sex, age, or disability, write immediately to: Administrator, Food and Nutrition Service, U.S. Department of Agriculture, 3101 Park Center Drive, Alexandria, VA 22302.

Version 3

WAIVER OF APPLICATION INFORMATION

Dear Parent/Guardian:

There is now affordable health insurance for children. This year, a new nationwide health insurance program is beginning. Now, most families who work hard to make ends meet can get low-cost or free health insurance for their children.

Children with health insurance are more likely to receive needed vaccinations and get treated for illnesses. Without treatment, these illnesses can slow a child's learning and have life long effects. If you do not have health insurance for your child, check the box below to receive information about free and low-cost health insurance for children.

Health Insurance ☐ Yes. I want health insurance for my child. School officials may give information from my free and reduced price school meal application to Medicaid or Children's Health Insurance Program (CHIP) officials. Medicaid and CHIP officials may use the information to help determine whether my child is eligible for either Medicaid or CHIP. Medicaid and CHIP officials may contact me for more information.

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child. I give up my rights to confidentiality for this purpose only.

I certify that I am the parent/guardian of the child for whom application is being made.

Signature of parent/guardian____

Printed name of parent/guardian:____

Address:____

____

____

Version 4

WAIVER OF NAME AND ADDRESS

Dear Parent/Guardian:

There is now affordable health insurance for children. This year, a new nationwide health insurance program is beginning. Now, most families who work hard to make ends meet can get low-cost or free health insurance for their children.

Children with health insurance are more likely to receive needed vaccinations and get treated for illnesses. Without treatment, these illnesses can slow a child's learning and have life long effects. If you do not have health insurance for your child, check the box below to receive information about free and low-cost health insurance for children.

Health Insurance ☐ Yes. I want health insurance for my child. School officials may give my name and address to Medicaid or the Children's Health Insurance Program officials so that they can send me information about free or low-cost health insurance for my child.

I understand that I will be releasing information that will show that I applied for free and reduced price school meals for my child. I give up my rights to confidentiality for this purpose only.

I certify that I am the parent/guardian of the child for whom application is being made.

Signature of parent/guardian____

Printed name of parent/guardian:____

Address:____

____

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Endnotes

[1] The departments include the Departments of Health and Human Services, Education, Agriculture, Justice, Labor, Housing and Urban Development, Commerce, and Interior; the Social Security Administration, Treasury, and the Environmental Protection Agency.

[2] Thomas M. Selden, Jessica S. Banthin, and Joel W. Cohen, "Medicaid's Problem Children: Eligible But Not Enrolled," *Health Affairs* 17 (May/June 1998): 192; U.S. Agency for Health Care Policy, Children's Health, 1996, Pub. No. 98-0008.

[3] Robert Wood Johnson Foundation Harvard University. University of Maryland, "National Survey of Americans' Views on Children's Health Care," December 9, 1997. Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie. "Southern Regional Initiatives to Improve Access to Benefits for Low Income Families with Children," Columbia, SC: Southern Institute on Children and Families, February 1998, pp. 8-10.

[4] Adapted from Wisconsin Department of Public Information and Great Lakes Resource Access Project, *Collaboration: Because It's Good for Children and Families* (Portage, Wis.: Wisconsin Department of Public Information and Great Lakes Resource Access Project, 1994) and included in Training Guides for the Head Start Learning Community, "Community Partnerships: Working Together," March 31, 1999, p. 20.

[5] Sharon L. Kagan and Ann Marie Rivera, "Collaboration in Early Care and Education: What Can and Should We Expect?," *Young Children*, November 1991.

[6] Atelia I. Melaville and Martin J. Blank with Gelareh Asayesh, *Together We Can: A Guide for Crafting a Profamily System of Education and Human Services*, pp. 30, 32.

[7] Patty Molloy, Cindy Rojas Rodriguez, and Gwen Chance, *The Early Care and Education Community Collaborative Tool Kit: A Collection of Activities to Support Collaboration and Early Care and Education*, August 1997, Texas Head Start-State Collaboration Project.

[8] *Training Guides for the Head Start Learning Community*, "Community Partnerships: Working Together," March 31, 1999, p.48.

[9] Kristi Olson, Jan Perkins, and Tonya Pate. *Executive Summary: Children's Health under Medicaid*, National Health Law Program, August 1998.

[10] Johnson Foundation. *National Survey of Americans' Views on Children's Health Care*, Harvard University 1997.

[11] Balanced Budget Act of 1997, P.L. 105-33, Subtitle J, Chapter 1, Section 2102.

[12] Office of the Assistant Secretary for Planning and Evaluation. *Trends in the Well-Being of America's Children and Youth*, 1997 Edition, Department of Health and Human Services; and Ron Pollack, "Number of Americans Without Health Care is Growing," *Families USA*, October 1998.

[13] Roberta Riportella-Miller, Maifa L. Selby-Harrington, Lenora A. Richardson, Patricia L.N. Donat, Kathryn J. Luchok, and Dana Quade. "Barriers to the Use of Preventive Health Care Services for Children," *Public Health Reports,* Vol. III, Jan./Feb. 1996.

[14] The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Lessons Learned, Opening Doors: Reducing Socio-cultural Barriers to Health Care,* August 1998.

[15] *The CHIP Communications Handbook*, a community-based organization's guide to promoting the Children's Health Insurance Program in local communities, pp. 51-62. The handbook was developed and reviewed by a group of children's supporters convened by Wyeth-Lederle Vaccines.